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 April 1, 2017

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

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TOP 10 THINGS TO KNOW ABOUT SOMB CHANGES

There are a number of changes that have and will occur as a result of the SOMB savings initiatives stated in the Amending Agreement. There are two sets of changes, Batch One that was implemented on January 1, 2017 and the second, Batch Two that will be implemented on April 1, 2017. You should be aware of all of the changes; the AMA encourages you to read the Billing Corners that are hosted on the AMA website. Batch one changes are already available on the Fee Navigator and Batch 2 changes will be made available on the Fee Navigator April 3. All of the changes are important but we have developed a list of the top 10 things to know about the changes, here they are in no particular order:

1. **BCP payments will be limited and the rates will be equalized across the province.**
    - BCP payments will pay a maximum of 50 units per day per physician regardless of how many eligible claims are submitted from any location in a given day.
    - BCP payments will be equalized so that there is one rate payable for the entire province. Currently Airdrie, DeWinton and Calgary receive a higher rate than anywhere else in the province. The rate for these areas will be reduced to the lower rate.
2. **Limits on the team and family conference codes**
    - 03.05JB
        - Will no longer be billable in addition to a visit at the same encounter
        - Will only be billable to a maximum of 3 hours (12 calls) per patient, per physician, per year.
    - 03.05JA and 03.05JC
        - Will only be billable to a maximum of 3 hours (12 calls) per patient, per physician, per year.
    - 08.19K
        - Will only be billable to a maximum of 2 calls (30 minutes) per patient, per physician, per week.
3. **Pre Op's for cataract procedures are no longer payable:**
    - The pre op for cataract procedures performed under local and or topical anesthetic is still required but will have to be completed by the operating surgeon. The <u>only time</u> the pre op medical (03.04M) will be paid in relation to cataract procedures, is if the patient is having their cataract performed under a general anesthetic. In those rare cases that require a general anesthetic, the operating surgeon will have to communicate the unique situation to the physician completing the pre op medical so that the information can be included in the text on the claim for the 03.04M pre op medical. If text is not submitted on the 03.04M for cataracts requiring a general anesthetic, the 03.04M will not be paid.

4. **Transfer of Care is not billable as a consult**
    - When transferring care of a patient to another physician either a visit code or a transfer of care code (for those specialties that have transfer of care codes) may be claimed. Claims for 03.08A where the service is for a transfer of care are not permitted.
5. **Changes to Medical emergency detention time, Resuscitation, MET team**
    - 13.99J
        - A maximum has been placed on the code
            - In the physician's office, a maximum of 8 calls or 2 hours may be claimed per day, per physician.
            - In any other location, a maximum of 16 calls or 4 hours may be claimed per physician per day.
    - 13.99E and 13.99EB
        - Both of these codes are now billed in 15 minute units. See Governing Rule 2.3.5 for more information on submitting claims for services that are described as "major portion thereof".
6. **Second Qualified Surgeon (SAQS) and Active Practice**
    - The SAQS modifier may be claimed when all of the criteria are met:
        - The complexities of a particular case require the specific skills of a second qualified surgeon assisting AND
        - The physician is considered to be in Active Practice (GR 1.31) meaning that they have acted as the primary surgeon for at least 5 procedures in the previous 12 months (and submitted claims as such) AND they have provided at least 10 or more of any of the following: 03.03A, 03.07A, 03.07B or 03.08A.
7. **Physician to Physician phone calls for consulting physicians**
    - In order to be paid for physician to physician phone calls 03.01LJ, 03.01LK, 03.01LL) you MUST enter in the referring physicians PRACID into the referring provider field. Claims submitted without a referring PRACID will not pay. This is meant to bring submissions for phone consultations in line with the process for billing all other consultations.

8. **Bone Mineral Densitometry and Inguinal Hernia ultrasounds**
    - BMD X128 ORDERING PHYSICIANS
        - A BMD may only be ordered for patients 50 years of age or older UNLESS the request for the exam is made by endocrinology, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedics, Pediatrics (including sub specialties), Physical Medicine or Rheumatology.
        - BMD's may only be performed once every two years, UNLESS the patient has a condition, medication regime or illness that requires more frequent BMDs. In those rare instances, please include this extra information in the request for the exam. Please see the Fee Navigator for more information.
    - INGUINAL HERNIA ULTRASOUNDS
        - May only be ordered when the request for the exam is made by a Urologist or a General Surgeon. In the case of pediatric patients, the request may be made by a General Practitioner, Pediatrician, Urologist or Pediatric General Surgeon.
9. **BMI Change to 40**
    - This change was made January 1, 2017. In order to submit a BMI claim for a patient, the patients BMI must be 40 or greater.
10. **Comprehensive visits limited to once every 365 days and pap code changes**
    - HSCs 03.04A, 03.08A, 03.08B, 03.08C, 03.08F, 03.08H, 03.08K, 08.11A, 08.11C, 08.19A and 08.19AA – may only be claimed once every 365 days, per patient per physician. AH has programmed a length of 345 days between services to accommodate for scheduling. If you claimed a 03.04A last June (2016) you may not claim another 03.04A (or other comprehensive) for another 365 days (keep in mind 345 day allowances).
    - 13.99BC pap smear/speculum exam code was DELETED January 1, 2016 and replaced with 13.99BA. The speculum exam code is 13.99BE
        - Pap smear code has been amended to be consistent with the TOP guidelines for pap screening. Patients aged 21-69 are eligible for paps, once per year. For those instances where age requirements are not met or more frequent paps are required, text on the claim describing the patient's condition must be submitted.

CHANGES IMPACTING ALL PHYSICIANS

03.01LJ Physician or podiatric surgeon to physician telephone or telehealth videoconference or secure videoconference consultation, consultant, weekdays 0700 to 1700 hours NOTE: Refer to notes following HSC 03.01LL.

03.01LK Physician 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
NOTE: Refer to notes following HSC 03.01LL.

03.01LL Physician 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 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 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 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.

AMA Billing Tip: 03.01LJ, 03.01LK and 03.01LL require a referring PRACID to be entered on the claims in order to receive payment.

03.03A 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
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.

03.05JA Formal, scheduled, multiple health discipline team conference, full 15 minutes or major portion thereof for the first call when only one call is claimed
With para-medical personnel regarding the provision of health care where social and other issues are involved
NOTE: 1. May be claimed when the conference involves the physician and one or more allied health professionals.
2. May be claimed by more than one physician where circumstances warrant (text will be required).
3. May be claimed to a maximum of 12 calls or 3 hours per year (April 1 to March 31), per patient, per physician.

> ***AMA Billing Tip:*** 03.05JA, 03.05JB and 03.05JC have been limited to a maximum number of 12 units (totaling 3 hours) per year. Physicians may submit multiple claims based on the time spent at each encounter. Physicians should be mindful that the maximums will be enforced and it will be the responsibility of the physician to keep track of the number of units submitted for payment in a year

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.
2. May be claimed to a maximum of 12 calls or three hours per year (April 1 to March 31), per patient, per physician.

> ***AMA Billing Tip:*** *0*3.05JB has been limited to a maximum number of 12 units (totaling 3 hours) per year. Physicians may submit multiple claims based on the time spent at each encounter. Physicians should be mindful that the maximums will be enforced and it will be the responsibility of the physician to keep track of the number of units submitted for payment in a year (April 1 – March 31).
> In addition to the limits, 03.03JB is no longer billable in addition to 03.03A at the same encounter. 03.05JB is a formal scheduled conference on behalf of a specific patient meaning the patient is not present and a specific request to speak with the physician at a scheduled time has been made.

03.05JC Family conference relating to acute care facility in-patient or registered emergency or out-patient, or auxiliary hospital, nursing home patient, AACC or UCC patient, per 15 minutes or major portion thereof
NOTE: 1. Intended specifically for patients whose condition warrants periodic family conferences~~. or for patients who are unable to properly communicate with their physician (e.g., situations where there is a language barrier, unconscious patient, etc.)~~
2. May be claimed to a maximum of 12 calls or 3 hours per year (April 1 to March 31), per patient, per physician.

> ***AMA Billing Tip:*** *03.*05JC has been limited to a maximum number of 12 units (totaling 3 hours) per year. Physicians may submit multiple claims based on the time spent at each encounter. Physicians should be mindful that the maximums will be enforced and it will be the responsibility of the physician to keep track of the number of units submitted for payment in a year (April 1 – March 31).
> The reference to language barrier has been removed to emphasize that this service is to be claimed for those patients that require periodic family conferences. If a physician sees a patient with a language barrier, the additional time spent completing the service as a result of the language or communication barrier may be claimed using complex modifiers.

03.05JR Physician telephone call directly to patient, to discuss patient management/diagnostic test results
NOTE: 1. A maximum of 7 telephone calls per physician, per calendar week may be claimed.
2. May not be claimed for management of patient's anticoagulant therapy (billable under HSC 03.01N).
3. May only be claimed when communication is provided by the physician.
4. Documentation of the communication to be recorded in the patient record.
5. May be claimed in addition to visits or other services provided on the same day, by the same physician.
6. Neither HSCs 03.01S or 03.01T are payable if HSC 03.05JR is claimed in the same calendar week by the same physician **for the same patient.**

> ***AMA Billing Tip:*** This change clarifies that the 03.05JR will pay, but 03.01S or 03.01T will reject if they are billed in the same calendar week. Only one non face to face service in this group of codes (03.05JR, 03.01A, 03.01T) is billable per week, per patient, per physician.

03.08A Comprehensive consultation
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.

AMA Billing Tip: The addition of note 2 clarifies the intent of the consultation code, request the opinion of a consulting physician. Transfer of care should be claimed as a visit, or as a transfer of care for those specialties that have transfer of care codes.
For example:

1) On the ward or in ICU: Physician A has been caring for an in-patient for a few days, Physician A is no longer on call or on the service for the remainder of the week, Physician B will now assume the call schedule or the service. Physician B **MAY NOT** claim a consultation for taking over the care of the patient, only a visit (03.03D) may be claimed when the patient is seen by Physician B. For those specialties with transfer of care codes (endocrinology/metabolism, general internal medicine, general surgery, cardiology, hematology, clinical immunology, medical oncology, and respiratory medicine) a transfer of care may be claimed providing the criteria are met.
2) In the ER: Physician A has assessed and/or started treatment on a patient. Physician A's shift is over and Physician B takes over. A consult is not permissible as this is considered a transfer of care and the appropriate follow up code should be claimed (03.05F series)
3) In the ER: A patient in the community is assessed by a physician and sent to the emergency for further care. This would be considered a transfer of care and should be billed using the most appropriate visit code by both physicians.

13.53B Intralesional injection(s) of steroid
NOTE: May not be claimed in addition to HSCs 16.89B, 16.89C or 16.89D.

13.59J Injection with local anesthetic of myofascial trigger points
NOTE: **1.** A maximum of three calls applies.
2. May not be claimed in addition to HSCs 16.89B, 16.89C or 16.89D.

13.62A Ventilatory support, in Intensive Care Unit (ICU)
NOTE: 1. Benefit includes endotracheal intubation with positive pressure ventilation, tracheal toilet, use of an artificial ventilator and continuous positive airway pressure (CPAP) through an artificial airway.
2. May only be claimed for services provided in approved level 2 and 3 and neonatal ICUs.
3. May only be claimed once per 24 hour period for any ventilated patient, irrespective of the number of physicians providing care.
4. May not be claimed for the same date of service by the same physician who provides either an anesthetic or surgical procedure.
5. May be claimed in association with other ICU services.
~~6. Benefits for unscheduled services may be claimed according to GR 15.~~

13.99E **Change to per 15 minutes from per 1 hour**
Resuscitation, ~~full 60~~ **per 15** minutes or a **major** portion thereof ~~for the first call when only one call is claimed~~
NOTE: 1. Resuscitation is defined as the emergency treatment of an unstable patient whose condition may result in imminent mortality without such intervention.
2. May be claimed when this service follows a consultation or hospital visit earlier in the same day as defined under GR 1.19.
~~3. After the first full 60 minutes has elapsed, each subsequent 15 minutes or portion thereof is payable at the rate specified in the Price List.~~
3. When the condition of the patient is such that further care is provided, either before or after the patient is resuscitated, at a level consistent with the description of HSC 13.99H, 13.99HA, 13.99J, 13.99K, 13.99KA or 13.99KB, time spent providing that care may be claimed using these HSCs. Concurrent claims for overlapping time for the same or different patients may not be claimed.
4. If two claims for HSC 13.99E at different encounters are submitted by the same or different physician, text is required.
5. Two physicians may not claim HSC 13.99E for concurrent care. **The second and subsequent physician involved in the resuscitation may claim HSC 13.99EC.**

> ***AMA Billing Tip:*** Each unit represents 15 minutes and may only be claimed for the total time that the physician spends providing personal and continuous resuscitation services. This service is not claimed on a cumulative time i.e. the physician can leave the patient and return and claim for the total time.
> Once the patient has stabilized and personal continuous physician attendance and resuscitation services are no longer required, physicians may submit claims using 13.99J or 13.99H providing the criteria for those services are met.

13.99J Medical emergency detention time, per 15 minutes
NOTE: 1. Time may be claimed on a cumulative basis per day (defined as 0001 to 2400), and may include time spent with the patient, review of patient history including diagnostics, review of patient prescriptions and other activities the physician does in relation to the patient's care on the same date of service.
2. Time spent providing services compensated elsewhere in the Schedule, e.g., family conferences and procedures, may not be included in time claimed for HSC 13.99J.
3. Supporting information must be submitted.
4. May be claimed by a physician during the time he/she is medically required to personally and continuously attend and treat an illness or injury of an emergency nature.
5. May not be claimed for such services as:
- counseling or psychotherapy except for crisis intervention situations;
- waiting for the results of laboratory or radiological examination;
- giving advice to family members or the patient;
- waiting for a family physician or consultant;
- attendance at labour or fetal monitoring (see HSC 13.99JA);
6. Detention time may not be claimed if the service was provided in the office in conjunction with routine visits except when it is documented that an emergency existed.
7. Illness of an "emergency nature" may apply to mental or emotional disorders as well as to physical illness.
8. If a visit benefit is claimed, the detention time benefit may not be claimed until thirty minutes after the start of the visit.
9. Only HSC 13.99J or procedures provided during the same encounter (with the exception of HSC 13.99E) may be claimed, but not both. Concurrent claims for overlapping time for the same or different patients may not be claimed.
10. A maximum of 16 calls per physician per day may be claimed in any location other than a physician's office.
11. A maximum of 8 calls per physician per day may be claimed in the physician's office.

AMA Billing Tip: Limits have been placed on this code so that a physician may not submit claims for more than 2 hours in a single day when the service is provided in their office. The 2 hours, or 8 calls, can be split up between patients but the total number of calls in a single day cannot exceed 8.
When services for medical emergency detention time are provided in any other location other than a physician's office, a maximum of 16 calls may be claimed in a single day. Be reminded that this service may only be claimed for the time that the physician has personally attended the patient or provided patient care regardless of how long the patient was detained or held.

95.94A Injection with local anesthetic of myofascial trigger points combined with a spray and stretch technique
NOTE: 1. A minimum of 30 minutes of stretching **per call** is required at the time of the injection.
2. A maximum of 8 calls may be claimed per physician per day.

> ***AMA Billing Tip:*** If the spray and stretch technique is not used, 13.59J Injection with local anesthetic of myofascial trigger points may be an appropriate code. Please note, acupuncture is not an insured service under the Alberta Health Care Insurance Plan (AHCIP).

GR 1.31 "Active Practice" is defined as a physician that has fulfilled both of the following criteria in the previous 12 months:
1) 5 or more procedures where the physician is acting as the primary surgeon AND
2) the physician has submitted claims and provided at least 10 or more of either or any combination of the following HSCs: 03.03A, 03.07A, 03.07B or 08.08A.

> ***AMA Billing Note:*** this definition provides the criteria that are required to be met in order for a physician to make a claim using the modifier SAQS – Second Assistant Qualified Second Surgeon.

GR 4.4.8 **ADD HSC's 03.01LJ, 03.01LK and 03.01LL (Physician to physician consultant phone call codes)**
REMOVE self-referral capability from X304

CLAIMS REQUIRING REFERRING PRACTITIONER NUMBER

When a claim is submitted for the following HSCs, the referring practitioner field must be completed with a valid referring practitioner number.

HSCs in the following list marked with an asterisk(*) cannot be self-referred. Self-referred means the physician is providing the diagnostic service and treating the patient.

HSCs in Section E (Lab and Pathology) and X (Diagnostic Radiology) require a valid referring practitioner number with the following exceptions:

HSC X27D does not require a referral and HSC X27F may be self- referred.

HSC 03.03D requires a valid referring physician, chiropractor, midwife, podiatrist, dentist, optometrist, physical therapist or nurse practitioner number when it is a visit to a referred patient.

GR 12.2.3 When providing procedural sedation in the emergency department, a consultation benefit may not be claimed in addition to the procedural sedation.

> ***AMA Billing Note:*** In these circumstances, only the anesthetic benefit may be claimed.

SAQS SURGICAL ASSISTANT QUALIFIED SECOND SURGEON - (Explicit) - A surgical specialist provides surgical assistance in unusual circumstances. This modifier may be claimed when the complexities of a particular surgical procedure on a particular patient require a second qualified, surgical specialist assisting. **May only be billed when the surgery requires the assistance of a qualified surgeon who is currently in an active surgical practice. If the surgery does not require a qualified surgeon, the SA (Surgical Assistant) modifier should be used.**

SSOS SECOND SURGEON ORTHOPEDIC SURGEON - (Explicit) - An orthopedic surgeon functions as a second surgeon during complex orthopedic surgery. This modifier may be claimed when the second surgeon has actively participated in the planning for and performance of the procedure. Only the second orthopedic surgeon's surgical time may be claimed; time spent in planning the procedure may not be included in the claimed time. **May only be billed when the surgery requires the assistance of a qualified surgeon who is currently in an active surgical practice. If the surgery does not require a qualified surgeon, the SA (Surgical Assistant) modifier should be used.**

X128 Bone mineral content determination dual photon absorptiometry with or without vertebral fracture assessment (VFA)
NOTE: 1. May only be claimed once every two years from the date of the last service.
2. For patients that are at high risk or have conditions that require more frequent assessments, text describing the circumstances will be required.
3. May only be claimed for patients 50 years of age or older unless the patient is referred by a Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

AMA Billing Tip: When ordering BMDs more frequently than once every two years, the ordering physician should make the providing physician aware of the specific need for more frequent tests. Claims for more frequent BMD's must be submitted with text that states the circumstances of the patient's condition, i.e. medication, illness. Please refer to the Fee Navigator for more information.

Other references and clinical indications for X128 ordering and performance are:

- Patient being monitored during a "bisphosphonate holiday"
- Patient on therapy in whom there are clinical features to question drug effect (i.e. fracture while on therapy)
- Patient is post transplant
- Patient has hyperparathyroidism
- Patient on supraphysiologic prednisone longer than 12 months

For patients that require a BMD prior to their 50th birthday, the request for the study will only be fulfilled if the request is made by one of the following specialties: Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

X313A Ultrasound, inguinal hernia
NOTE: 1. May only be claimed when the referral is supplied by a urologist (UROL) or general surgeon (GNSG). For pediatric patients, a general practitioner (GP), pediatrician (PED), urologist (UROL) or pediatric general surgeon (PDSG) may also make referrals.

AMA Billing Note: Minimally symptomatic hernias do not necessarily require an ultrasound.
If the inguinal hernia is likely surgical or symptomatic, the appropriate referral should be made, the surgical specialist will determine if an ultrasound is necessary.

SECTION OF ANESTHESIA

01.22 Other nonoperative colonoscopy
NOTE: 1. HSCs 13.99AE, 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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. Refer to HSCs 01.22A, 01.22B and 01.22C for screening.

01.22A Other nonoperative colonoscopy for screening of high risk patients
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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 for screening purposes for those patients that have been considered to be of high risk for colon cancer.
5. High risk is defined as an individual that has a strong family history of colorectal cancer with multiple individuals affected but no genetic syndrome identified family history of Hereditary Non-Polyposis Colorectal Cancer or a personal history of inflammatory bowel disease.
6. May be claimed once every year.

01.22B Other nonoperative colonoscopy for screening of moderate risk patients
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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 for screening purposes for those patients that have been considered to be of moderate risk for colon cancer.
5. Moderate risk is defined as an individual who has one or more first degree relatives with colorectal cancer or personal history of colorectal adenomatous polyps.
6. May be claimed once every 5 years.

01.22C Other nonoperative colonoscopy for screening of average risk patients
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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 for screening purposes for those patients that have been considered to be of average risk for colon cancer.
5. Average risk is defined as an individual that is asymptomatic and aged 50 to 74 years.
6. May be claimed once every 10 years.

01.24B Flexible proctosigmoidoscopy, diagnostic only
NOTE: 1. HSCs 13.99AE, 57.13A, 57.21A, 57.21B, 58.99C 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.

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 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.

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 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.

16.89D Percutaneous facet joint injection - Lumbar/Sacral
NOTE: 1. A maximum of four calls may be made per patient, per day regardless of level (HSCs 16.89B, 16.89C or 16.89D).
2. A maximum of twelve calls may be claimed per patient, per benefit year regardless of level (HSCs 16.89B, 16.89C or 16.89D).
3. HSCs 16.89B, 16.89C and 16.89D may not be claimed in addition to HSCs 13.59B, 13.59J, 92.78B or 92.78C.
4. HSCs X 55 or X 56 may only be claimed in addition to HSCs 16.89B, 16.89C or 16.89D once per year, per patient.

16.91G Epidural analgesia for labour and delivery, monitoring and/or top-up/adjustment, each additional full 5 minutes, per patient
NOTE: 1. May be claimed by an on-site physician when immediately available or when called to monitor or reassess the patient or top-up/adjust analgesia.
2. HSC 16.91G may not be claimed for the same patient until 35 minutes has elapsed from the time of the initiation of the HSC 16.91C recognizing that HSC 16.91C represents a full 30 minutes.
3. Concurrent billing for overlapping time for separate patient encounters/services may not be claimed.
4. Anesthetic benefits for a vaginal delivery by the same or a different physician may not be claimed in addition to HSCs 16.91C or 16.91G.
5. HSC 16.91F may be claimed for attendance at a forceps/vacuum delivery, vaginal breech delivery or vaginal delivery multiple birth, where an epidural was previously established by the same or different physician.
6. Listed anesthetic benefits for Cesarean section may be claimed in addition but not concurrently with HSC16.91G, see Note 3.
7. A maximum of ~~two~~ **one** surcharge benefit (SURC) for HSC 16.91G may be claimed per physician, per patient, if applicable, in accordance with GR 15.

> ***AMA Billing Tip:*** The BMI modifier has been removed from the 16.91G. The other change is that the surcharges for the 16.91G have been reduced to one per patient per physician when the criteria under GR 15 are met.
> The BMI (BMI of 40 or greater) and the surcharge modifiers still apply to the 16.91C Epidural catheter insertion for labor analgesia including set-up and initial injection.

57.21A Polypectomy of large intestine, additional benefit
NOTE: **1. May only be claimed for the removal of polyps that are greater than 5mm in size.**
~~1~~**2**. May only be claimed with HSCs 01.16B, 01.16C, 01.22, 01.22A, 01.22B, 01.22C, **01.24B**, 01.24BA and 01.24BB and when the removal of a colonic mucosal lesion is performed using a polypectomy snare (with or without electrocautery)or a hot biopsy forceps.
3. May be claimed in addition to HSC 57.21C if polyps are removed from different sites.
4May not be claimed when a regular biopsy forceps is used to remove a diminutive polyp without electrocautery, even if multiple passes are required.
5. Benefit includes placement of clips at the time of polypectomy.
6. Each additional polyp may be claimed at the rate specified on the Price List; a maximum benefit of six calls applies.

SECTION OF CARDIOLOGY

X306 **DELETE HSC**
Ultrasound, heart, echocardiogram, complete study
NOTE: May not be claimed in addition to HSCs X307, X323 and X337.

X306A **Complex Complete Echocardiogram**
NOTE: 1. A complex complete echocardiogram includes all elements of an X306B, where the study is performed to confirm, assess, diagnose or follow-up on a patient that has, or previously had any of the following:
-pericardial disease, cardiomyopathy
-valve repair and/or valve replacement
-ventricular assist devices
-moderate or worse left ventricular systolic dysfunction (ASE guideline reference LVEF equal or less than 40%)
-vegetation, thrombus or cardiac mass
-moderate or worse valvular stenosis or regurgitation (ASE guideline references- specifically excludes mild to moderate)
-congenital heart disease (repaired or unrepaired; excludes patient foramen ovale unless bubble study is requested or indicated
2. Also payable in cases where the performance and interpretation of contrast injection (agitated saline or echo contrast), or stress echocardiography are completed.
3. Benefit includes rescanning (i.e. image acquisition) by a qualified physician, if performed.
4. In the rare case where a specific view or Doppler signal is inavailable, the reason shall be documented in the patient's record.
5. May not be claimed in addition to HSCs X307, X323 and X337.

X306B **Non Complex Complete Echocardiogram**
A study of all the relevant cardiac structures and functions of all the chambers, valves, septae, pericardium and great vessels from multiple views, complemented by Doppler examination of every cardiac valve, the atrial and ventricular septa for antegrade and retrograde flow.
NOTE: May not be claimed in addition to HSCs X307, X323 and X337.

X307 Ultrasound, heart, Echocardiogram, limited
NOTE: May not be claimed in addition to HSC X306**A or X306B.**

X323 Ultrasound, heart (Echocardiogram), fetal, complete study
NOTE: 1. May not be claimed in addition to HSC X306**A, X306B** and X337.
2. An additional 100% of the benefit may be claimed for each additional fetus.

X337 Doppler, quantitative spectral analysis with directional flow and/or Doppler measurements (e.g. renal artery, portal venous system, resistivity index, etc.), additional benefit
NOTE: May not be billed in addition to HSCs X304, X306**A**, **X306B,** X323, X330, X331, X332, X333, X334 and X335 when services are provided by the same or different physician in the same facility on the same day.

SECTION OF CRITICAL CARE MEDICINE

13.99EB **Change to per 15 minutes from per 1 hour**
Medical Emergency Team Co-ordination by lead physician, **per full 15 minutes or major portion thereof**
NOTE: 1. Benefit includes patient assessment and necessary interventions including priority attendance, initial stabilization of patient with establishment of peripheral intravenous access, administration of oxygen, insertion of urinary catheter, initiation of appropriate medications and airway control for 'life-threatening' calling criteria.
2. May only be claimed by a Critical Care Specialists whose role is to respond as part of a recognized hospital Rapid Response or Medical Emergency Team when patients fulfill activation criteria and where intervention by physician is required to prevent death or support failing organ systems.
~~3. After the first full 60 minutes has elapsed, each subsequent 15 minutes or major portion thereof is payable at the rate specified in the price list.~~
~~4. May not be claimed in addition to HSC 13.99E.~~
3. Concurrent claims for overlapping time for the same or different patients may not be claimed.
4. If two claims for HSC 13.99EB at different encounters are submitted by the same or different physician, text is required.
5. Two physicians may not claim HSC 13.99EB or 13.99E for concurrent care on the same day.

> ***AMA Billing Tip:*** Each unit represents 15 minutes and may only be claimed for the total time that the physician spends providing personal and continuous MET attendance. This service is **NOT** claimed on cumulative time, the physician must be in attendance with the patient for the total time.

49.98B Pharmacological manipulation of physiological function and recording thereof
NOTE: **1.** May be claimed in addition to cardiac catheterization.
2. May only be claimed once per day, per patient, per physician.

49.98C Physical manipulation of physiological function and recording thereof
NOTE**: 1.** May be claimed in addition to cardiac catheterization.
2. May only be claimed once per day, per patient, per physician.

49.98D Electrical manipulation of physiological function and recording thereof
NOTE: **1.** May be claimed in addition to cardiac catheterization.
2. May only be claimed once per day, per patient, per physician.

SECTION OF DERMATOLOGY

98.12H Excision of soft tissue tumor(s) (subcutaneous) full 30 minutes of operating time or **major** portion thereof for the first call when only one call is claimed
NOTE: 1. For sebaceous cyst removal see HSC 98.12C.
2. After the first full 30 minutes has elapsed, each subsequent 15 minutes or **major** portion thereof, is payable at the rate specified in the Price List; a maximum benefit applies.

SECTION OF DIAGNOSTIC IMAGING

16.89D Percutaneous facet joint injection - Lumbar/Sacral
NOTE: 1. A maximum of four calls may be made per patient, per day regardless of level (HSCs 16.89B, 16.89C or 16.89D).
2. A maximum of twelve calls may be claimed per patient, per benefit year regardless of level (HSCs 16.89B, 16.89C or 16.89D).
3. HSCs 16.89B, 16.89C and 16.89D may not be claimed in addition to HSCs 13.59B, 13.59J, 92.78B or 92.78C.
4. HSCs X 55 or X 56 may only be claimed in addition to HSCs 16.89B, 16.89C or 16.89D once per year, per patient.

XRAY XRAY STUDIES - (Explicit) - Used to indicate that an xray was performed with the use of video, stereo, or cine studies **or that tomography was used in addition to mammography services.**

CINE CINE - (Explicit) - Indicates xray involved cine.
STEREO STEREO - (Explicit) - Indicates xray involved stereo.
VIDEO VIDEO - (Explicit) - Indicates xray involved video.

TOMO TOMOGRAPHY – (Explicit) – Indicates tomography is used in addition to mammography services.

> ***AMA Billing Tip:*** the TOMO modifier is claimed in addition to mammography services where tomography is used. The modifier replaces the billing practice of claiming X105 in addition to the mammography codes.

X1 Skull
NOTE: May not be claimed in addition to HSC X 4.

X4 Facial bones
NOTE: May not be claimed in addition to HSC X 1.

X26 **ADD Modifier XRAY TOMO**
Mammography (one breast)
NOTE: May not be claimed in addition to HSC**s X105 or** X105A.

X27 **ADD Modifier XRAY TOMO**
Mammography (both breasts)
NOTE: May not be claimed in addition to HSC**s X105 or** X105A.

X27C **ADD Modifier XRAY TOMO**
Screening mammography (age 40 to 49 years inclusive)
NOTE: Refer to notes following X27E for further information.

X27D **ADD Modifier XRAY TOMO**
Screening mammography (age 50 to 74 years inclusive)
NOTE: Refer to note following X27E for further information.

X27E **ADD Modifier XRAY TOMO**
Screening mammography (age 75 and over)
NOTE: 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 Cancer Board.
7. X27C, X27D or X27E may not be claimed in addition to HSCs **X105** and X105A.

X27G **ADD Modifier XRAY TOMO**
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: May not be claimed in addition to HSC X105A.

X55 One area
NOTE: **1.** May not be claimed in addition to HSCs X 54A and X 54B.
2. May only be claimed in addition to HSCs 16.89B, 16.89C or 16.89D once per year.

X56 One area - with obliques
NOTE**: 1.** May not be claimed in addition to HSCs X 54A and X 54B.
2. May only be claimed in addition to HSCs 16.89B, 16.89C or 16.89D once per year.

X68 **Kidney, ureters, bladder** (K.U.B.)
NOTE: May not be claimed in addition to HSCs X 98, X 99 or X100.

X86 Colon (with fluoroscopy and films)
NOTE: May not be claimed in addition to HSCs X 87 or X 88.

X87 Colon (with fluoroscopy and films) combined with air contrast examination
NOTE: May not be claimed in addition to HSCs X 86 or X 88.

X88 Colon - separate air contrast (fluoroscopy and films)
NOTE: May not be claimed in addition to HSCs X 86 or X 87.

X98 Abdomen - single view
NOTE: May not be claimed in addition to HSCs X 68, X 99 or X100.

X99 Abdomen - multiple views
NOTE: May not be claimed in addition to HSCs X 68, X 98 or X100.

X100 Abdomen for obstruction or perforation
NOTE: May not be claimed in addition to HSCs X 68, X 98 or X 99.

X105 Planogram (tomogram, laminogram) - including stereos and fluoroscopy when necessary - any area
NOTE: May not be claimed in addition to HSCs X 26, X 27, X 27C, X 27D, X 27E or X 27G.

X128 Bone mineral content determination dual photon absorptiometry with or without vertebral fracture assessment (VFA)
NOTE: 1. May only be claimed once every two years from the date of the last service.
2. For patients that are at high risk or have conditions that require more frequent assessments, text describing the circumstances will be required.
3. May only be claimed for patients 50 years of age or older unless the patient is referred by a Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

AMA Billing Tip: When ordering BMDs more frequently than once every two years, the ordering physician should make the providing physician aware of the specific need for more frequent tests. Claims for more frequent BMD's must be submitted with text that states the circumstances of the patient's condition, i.e. medication, illness. Please refer to the Fee Navigator for more information.

Other references and clinical indications for X128 ordering and performance are:

- Patient being monitored during a "bisphosphonate holiday"
- Patient on therapy in whom there are clinical features to question drug effect (i.e. fracture while on therapy)
- Patient is post transplant
- Patient has hyperparathyroidism
- Patient on supraphysiologic prednisone longer than 12 months

For patients that require a BMD prior to their 50th birthday, the request for the study will only be fulfilled if the request is made by one of the following specialties: Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

X306 **DELETE HSC**
Ultrasound, heart, echocardiogram, complete study
NOTE: May not be claimed in addition to HSCs X307, X323 and X337.

X306A Complex Complete Echocardiogram
NOTE: 1. A complex complete echocardiogram includes all elements of an X306B, where the study is performed to confirm, assess, diagnose or follow-up on a patient that has, or previously had any of the following:
-pericardial disease, cardiomyopathy
-valve repair and/or valve replacement
-ventricular assist devices
-moderate or worse left ventricular systolic dysfunction (ASE guideline reference LVEF equal or less than 40%)
-vegetation, thrombus or cardiac mass
-moderate or worse valvular stenosis or regurgitation (ASE guideline references- specifically excludes mild to moderate)
-congenital heart disease (repaired or unrepaired; excludes patient foramen ovale unless bubble study is requested or indicated
2. Also payable in cases where the performance and interpretation of contrast injection (agitated saline or echo contrast), or stress echocardiography are completed.
3. Benefit includes rescanning (i.e. image acquisition) by a qualified physician, if performed.
4. In the rare case where a specific view or Doppler signal is unavailable, the reason shall be documented in the patient's record.
5. May not be claimed in addition to HSCs X307, X323 and X337.

X306B Non Complex Complete Echocardiogram
A study of all the relevant cardiac structures and functions of all the chambers, valves, septae, pericardium and great vessels from multiple views, complemented by Doppler examination of every cardiac valve, the atrial and ventricular septa for antegrade and retrograde flow.
NOTE: May not be claimed in addition to HSCs X307, X323 and X337.

X307 Ultrasound, heart, Echocardiogram, limited
NOTE: May not be claimed in addition to HSC X306**A or X306B.**

X313 Ultrasound, abdominal wall~~, hernia~~ or appendix study
NOTE: Supporting text is required when a third call is claimed

X313A **Ultrasound, inguinal hernia**
NOTE: 1. May only be claimed when the referral is supplied by a urologist (UROL) or general surgeon (GNSG). For pediatric patients, a general practitioner (GP), pediatrician (PED), urologist (UROL) or pediatric general surgeon (PDSG) may also make referrals.

> ***AMA Billing Note:*** Minimally symptomatic hernias do not necessarily require an ultrasound.
> If the inguinal hernia is likely surgical or symptomatic, the appropriate referral should be made, the surgical specialist will determine if an ultrasound is necessary.

X323 Ultrasound, heart (Echocardiogram), fetal, complete study
NOTE: 1. May not be claimed in addition to HSC X306**A, X306B** and X337.
2. An additional 100% of the benefit may be claimed for each additional fetus.

X337 Doppler, quantitative spectral analysis with directional flow and/or Doppler measurements (e.g. renal artery, portal venous system, resistivity index, etc.), additional benefit
NOTE: May not be billed in addition to HSCs X304, X306**A**, **X306B,** X323, X330, X331, X332, X333, X334 and X335 when services are provided by the same or different physician in the same facility on the same day.

SECTION OF ENDOCRINOLOGY AND METABOLISM

X128 Bone mineral content determination dual photon absorptiometry with or without vertebral fracture assessment (VFA)

NOTE: 1. May only be claimed once every two years from the date of the last service.

2. For patients that are at high risk or have conditions that require more frequent assessments, text describing the circumstances will be required.

3. May only be claimed for patients 50 years of age or older unless the patient is referred by a Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

AMA Billing Tip: When ordering BMDs more frequently than once every two years, the ordering physician should make the providing physician aware of the specific need for more frequent tests. Claims for more frequent BMD's must be submitted with text that states the circumstances of the patient's condition, i.e. medication, illness. Please refer to the Fee Navigator for more information.

Other references and clinical indications for X128 ordering and performance are:

- Patient being monitored during a "bisphosphonate holiday"
- Patient on therapy in whom there are clinical features to question drug effect (i.e. fracture while on therapy)
- Patient is post transplant
- Patient has hyperparathyroidism
- Patient on supraphysiologic prednisone longer than 12 months

For patients that require a BMD prior to their 50th birthday, the request for the study will only be fulfilled if the request is made by one of the following specialties: Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

SECTION OF GASTROENTEROLOGY

01.22 Other nonoperative colonoscopy
NOTE: 1. HSCs 13.99AE, 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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. Refer to HSCs 01.22A, 01.22B and 01.22C for screening.

01.22A Other nonoperative colonoscopy for screening of high risk patients
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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 for screening purposes for those patients that have been considered to be of high risk for colon cancer.
5. High risk is defined as an individual that has a strong family history of colorectal cancer with multiple individuals affected but no genetic syndrome identified family history of Hereditary Non-Polyposis Colorectal Cancer or a personal history of inflammatory bowel disease.
6. May be claimed once every year.

01.22B Other nonoperative colonoscopy for screening of moderate risk patients
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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 for screening purposes for those patients that have been considered to be of moderate risk for colon cancer.
5. Moderate risk is defined as an individual who has one or more first degree relatives with colorectal cancer or personal history of colorectal adenomatous polyps.
6. May be claimed once every 5 years.

01.22C Other nonoperative colonoscopy for screening of average risk patients
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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 for screening purposes for those patients that have been considered to be of average risk for colon cancer.
5. Average risk is defined as an individual that is asymptomatic and aged 50 to 74 years.
6. May be claimed once every 10 years.

01.24B Flexible proctosigmoidoscopy, diagnostic only
NOTE: 1. HSCs 13.99AE, 57.13A, 57.21A, 57.21B, 58.99C 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.

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 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.

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 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.

57.13A Bipolar electrocoagulation/heater probe hemostasis or endoclip placement or argon plasma coagulation for bleeding lesions of the colon following an initial procedure at a separate encounter, additional benefit
NOTE: 1. May only be claimed in addition to HSCs 01.16B**, 01.16C**, 01.22, 01.22A, 01.22B, 01.22C, 01.24B, 01.24BA and 01.24BB.
2. May only be claimed in situations where the patient has post-polypectomy bleeding following an initial procedure and must undergo a repeat procedure to manage post- polypectomy bleeding.
3. May not be claimed for services provided at the same encounter as the initial polypectomy.

57.21A Polypectomy of large intestine, additional benefit
NOTE: **1. May only be claimed for the removal of polyps that are greater than 5mm in size.**
~~1~~**2**. May only be claimed with HSCs 01.16B, 01.16C, 01.22, 01.22A, 01.22B, 01.22C, **01.24B**, 01.24BA and 01.24BB and when the removal of a colonic mucosal lesion is performed using a polypectomy snare (with or without electrocautery)or a hot biopsy forceps.
3. May be claimed in addition to HSC 57.21C if polyps are removed from different sites.
4May not be claimed when a regular biopsy forceps is used to remove a diminutive polyp without electrocautery, even if multiple passes are required.
5. Benefit includes placement of clips at the time of polypectomy.
6. Each additional polyp may be claimed at the rate specified on the Price List; a maximum benefit of six calls applies

X128 Bone mineral content determination dual photon absorptiometry with or without vertebral fracture assessment (VFA)
NOTE: 1. May only be claimed once every two years from the date of the last service.
2. For patients that are at high risk or have conditions that require more frequent assessments, text describing the circumstances will be required.
3. May only be claimed for patients 50 years of age or older unless the patient is referred by a Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

AMA Billing Tip: When ordering BMDs more frequently than once every two years, the ordering physician should make the providing physician aware of the specific need for more frequent tests. Claims for more frequent BMD's must be submitted with text that states the circumstances of the patient's condition, i.e. medication, illness. Please refer to the Fee Navigator for more information.

Other references and clinical indications for X128 ordering and performance are:

- Patient being monitored during a "bisphosphonate holiday"
- Patient on therapy in whom there are clinical features to question drug effect (i.e. fracture while on therapy)
- Patient is post transplant
- Patient has hyperparathyroidism
- Patient on supraphysiologic prednisone longer than 12 months

For patients that require a BMD prior to their 50th birthday, the request for the study will only be fulfilled if the request is made by one of the following specialties: Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

SECTION OF GENERAL PRACTICE

01.22 Other nonoperative colonoscopy
NOTE: 1. HSCs 13.99AE, 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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. Refer to HSCs 01.22A, 01.22B and 01.22C for screening.

01.22A Other nonoperative colonoscopy for screening of high risk patients
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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 for screening purposes for those patients that have been considered to be of high risk for colon cancer.
5. High risk is defined as an individual that has a strong family history of colorectal cancer with multiple individuals affected but no genetic syndrome identified family history of Hereditary Non-Polyposis Colorectal Cancer or a personal history of inflammatory bowel disease.
6. May be claimed once every year.

01.22B Other nonoperative colonoscopy for screening of moderate risk patients
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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 for screening purposes for those patients that have been considered to be of moderate risk for colon cancer.
5. Moderate risk is defined as an individual who has one or more first degree relatives with colorectal cancer or personal history of colorectal adenomatous polyps.
6. May be claimed once every 5 years.

01.22C Other nonoperative colonoscopy for screening of average risk patients
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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 for screening purposes for those patients that have been considered to be of average risk for colon cancer.
5. Average risk is defined as an individual that is asymptomatic and aged 50 to 74 years.
6. May be claimed once every 10 years.

01.24B Flexible proctosigmoidoscopy, diagnostic only
NOTE: 1. HSCs 13.99AE, 57.13A, 57.21A, 57.21B, 58.99C 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.

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 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.

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 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.

03.04M Pre-operative history and physical examination in relation to an insured service
NOTE: 1. May only be claimed when an examination and a standard form for pre-operative assessment have been completed.
2. A copy of the form must be retained in the patient's chart.
3. May not be claimed in addition to a surgical assist (SA, SAQS, SSOS) for the same patient by the same physician.
4. HSC 03.04M may not be claimed for a pre operative physical examination when the request is for a cataract procedure (HSC 27.72A) that will not require the use of a general anesthetic.

AMA Billing Tip: The pre op for cataract procedures performed under local and or topical anesthetic is still required but will have to be completed by the operating surgeon. The only time the pre op medical (03.04M) will be paid in relation to cataract procedures, is if the patient is having their cataract performed under a general anesthetic. In those rare cases that require a general anesthetic, the operating surgeon will have to communicate the unique situation to the physician completing the pre op medical so that the information can be included in the text on the claim for the 03.04M pre op medical. If text is not submitted on the 03.04M for cataracts requiring a general anesthetic, the 03.04M will not be paid.

08.19K Second and subsequent physician attendance at a formal, scheduled, professional conference related to the care and treatment of multiple psychiatric patients, when discussion occurs on behalf of a specific patient
NOTE: 1. **HSCs** 08.19J and 08.19K may only be claimed by general practice physicians, generalists in Mental Health, pediatricians, psychiatrists, community medicine specialists and specialists in Mental Health.
2. **HSCs** 08.19J and 08.19K are to be claimed using the Personal Health Number of the patient, naming the personnel, agencies or organizations involved.
3. Each physician involved in a patient conference may claim for patient services using **HSC** 08.19J or 08.19K, per patient, to a maximum of 6 patients in a 30-minute period.
4. **HSC** 08.19K may be claimed when the physician most responsible for the patient's care has submitted a claim under HSC 08.19J.
5. HSC 08.19K may be claimed to a maximum of 2 calls per patient, per week, per physician.

57.21A Polypectomy of large intestine, additional benefit
NOTE: **1. May only be claimed for the removal of polyps that are greater than 5mm in size.**
2. May only be claimed with HSCs 01.16B, 01.16C, 01.22, 01.22A, 01.22B, 01.22C, **01.24B,** 01.24BA and 01.24BB and when the removal of a colonic mucosal lesion is performed using a polypectomy snare (with or without electrocautery)or a hot biopsy forceps.
3. May be claimed in addition to HSC 57.21C if polyps are removed from different sites.
4May not be claimed when a regular biopsy forceps is used to remove a diminutive polyp without electrocautery, even if multiple passes are required.
5. Benefit includes placement of clips at the time of polypectomy.
6. Each additional polyp may be claimed at the rate specified on the Price List; a maximum benefit of six calls applies.

75.64 Vasectomy (complete) (partial)
NOTE: May not be claimed if vasectomy is subsequent to a previous reversal. If a repeat procedure is required due to a previously failed attempt, supporting documentation must be provided.

> ***AMA Billing Tip:*** If a patient previously had an insured vasectomy followed by a reversal, the second vasectomy is not considered to be an insured service and should be billed to the patient.

78.99B Other tubal sterilization, any method
NOTE: May not be claimed if sterilization is subsequent to a previous reversal. If a repeat procedure is required due to a previously failed attempt, supporting documentation must be provided.

> ***AMA Billing Tip:*** If a patient previously had an insured tubal sterilization followed by a reversal, the second tubal sterilization is not considered to be an insured service and should be billed to the patient.

80.19E Endometrial ablation by any non-hysteroscopic method (e.g. microwave, thermablate, etc.)
NOTE: **May not be claimed in addition** to HSC 80.81 ~~may be claimed in addition.~~

98.12H Excision of soft tissue tumor(s) (subcutaneous) full 30 minutes of operating time or **major** portion thereof for the first call when only one call is claimed
NOTE: 1. For sebaceous cyst removal see HSC 98.12C.
2. After the first full 30 minutes has elapsed, each subsequent 15 minutes or **major** portion thereof, is payable at the rate specified in the Price List; a maximum benefit applies.

X313A Ultrasound, inguinal hernia
NOTE: 1. May only be claimed when the referral is supplied by a urologist (UROL) or general surgeon (GNSG). For pediatric patients, a general practitioner (GP), pediatrician (PED), urologist (UROL) or pediatric general surgeon (PDSG) may also make referrals.

> ***AMA Billing Note:*** Minimally symptomatic hernias do not necessarily require an ultrasound.
> If the inguinal hernia is likely surgical or symptomatic, the appropriate referral should be made, the surgical specialist will determine if an ultrasound is necessary.

SECTION OF GENERAL SURGERY

01.22 Other nonoperative colonoscopy
NOTE: 1. HSCs 13.99AE, 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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. Refer to HSCs 01.22A, 01.22B and 01.22C for screening.

01.22A Other nonoperative colonoscopy for screening of high risk patients
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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 for screening purposes for those patients that have been considered to be of high risk for colon cancer.
5. High risk is defined as an individual that has a strong family history of colorectal cancer with multiple individuals affected but no genetic syndrome identified family history of Hereditary Non-Polyposis Colorectal Cancer or a personal history of inflammatory bowel disease.
6. May be claimed once every year.

01.22B Other nonoperative colonoscopy for screening of moderate risk patients
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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 for screening purposes for those patients that have been considered to be of moderate risk for colon cancer.
5. Moderate risk is defined as an individual who has one or more first degree relatives with colorectal cancer or personal history of colorectal adenomatous polyps.
6. May be claimed once every 5 years.

01.22C Other nonoperative colonoscopy for screening of average risk patients
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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 for screening purposes for those patients that have been considered to be of average risk for colon cancer.
5. Average risk is defined as an individual that is asymptomatic and aged 50 to 74 years.
6. May be claimed once every 10 years.

01.24B Flexible proctosigmoidoscopy, diagnostic only
NOTE: 1. HSCs 13.99AE, 57.13A, 57.21A, 57.21B, 58.99C 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.

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 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.

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 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.

52.2 Regional lymph node excision
That for TB etc
NOTE: May not be claimed in addition to HSC 63.69A.

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 HSC**s** 57.42A **or 63.69A.**

57.13A Bipolar electrocoagulation/heater probe hemostasis or endoclip placement or argon plasma coagulation for bleeding lesions of the colon following an initial procedure at a separate encounter, additional benefit
NOTE: 1. May only be claimed in addition to HSCs 01.16B**, 01.16C**, 01.22, 01.22A, 01.22B, 01.22C, 01.24B, 01.24BA and 01.24BB.
2. May only be claimed in situations where the patient has post-polypectomy bleeding following an initial procedure and must undergo a repeat procedure to manage post- polypectomy bleeding.
3. May not be claimed for services provided at the same encounter as the initial polypectomy.

57.21A Polypectomy of large intestine, additional benefit
NOTE: **1. May only be claimed for the removal of polyps that are greater than 5mm in size.**
2. May only be claimed with HSCs 01.16B, 01.16C, 01.22, 01.22A, 01.22B, 01.22C, **01.24B**, 01.24BA and 01.24BB and when the removal of a colonic mucosal lesion is performed using a polypectomy snare (with or without electrocautery)or a hot biopsy forceps.
3. May be claimed in addition to HSC 57.21C if polyps are removed from different sites.
4May not be claimed when a regular biopsy forceps is used to remove a diminutive polyp without electrocautery, even if multiple passes are required.
5. Benefit includes placement of clips at the time of polypectomy.
6. Each additional polyp may be claimed at the rate specified on the Price List; a maximum benefit of six calls applies.

62.2B Lobectomy of liver - 4 or more hepatic segments
NOTE: May not be claimed in addition to HSC**s** 62.12C**,** ~~or~~ 63.12B **or 63.69A.**

62.12C Partial resection of liver
NOTE: 1. May not be claimed for wedge biopsy.
2. May not be claimed in addition to HSC 62.2 B, ~~or~~ 63.12B **or 63.69A.**

65.1 B Repair of inguinal or femoral hernia, including mesh

> ***AMA Billing Tip:*** The introduction of this code is to recognize that there has not been a code to capture repair of non recurrent hernias using mesh.

97.29A Simple mastectomy, **includes that for gynecomastia**
NOTE: 1. ~~Includes that for gynecomastia~~ **May only be claimed for:**
-pediatric gynecomastia (i.e. below the age of 18),
-symptomatic gynecomastia such as breast pain,
-prophylactic mastectomies for patients who are breast cancer gene positive or have a strong family history of breast cancer.
2. For cases other than those involving malignancies.

X128 Bone mineral content determination dual photon absorptiometry with or without vertebral fracture assessment (VFA)
NOTE: 1. May only be claimed once every two years from the date of the last service.
2. For patients that are at high risk or have conditions that require more frequent assessments, text describing the circumstances will be required.
3. May only be claimed for patients 50 years of age or older unless the patient is referred by a Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

AMA Billing Tip: When ordering BMDs more frequently than once every two years, the ordering physician should make the providing physician aware of the specific need for more frequent tests. Claims for more frequent BMD's must be submitted with text that states the circumstances of the patient's condition, i.e. medication, illness. Please refer to the Fee Navigator for more information.

Other references and clinical indications for X128 ordering and performance are:

- Patient being monitored during a "bisphosphonate holiday"
- Patient on therapy in whom there are clinical features to question drug effect (i.e. fracture while on therapy)
- Patient is post transplant
- Patient has hyperparathyroidism
- Patient on supraphysiologic prednisone longer than 12 months

For patients that require a BMD prior to their 50th birthday, the request for the study will only be fulfilled if the request is made by one of the following specialties: Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

X313A Ultrasound, inguinal hernia
NOTE: 1. May only be claimed when the referral is supplied by a urologist (UROL) or general surgeon (GNSG). For pediatric patients, a general practitioner (GP), pediatrician (PED), urologist (UROL) or pediatric general surgeon (PDSG) may also make referrals.

AMA Billing Note: Minimally symptomatic hernias do not necessarily require an ultrasound.
If the inguinal hernia is likely surgical or symptomatic, the appropriate referral should be made, the surgical specialist will determine if an ultrasound is necessary.

SECTION OF GENERALISTS IN MENTAL HEALTH

08.19K Second and subsequent physician attendance at a formal, scheduled, professional conference related to the care and treatment of multiple psychiatric patients, when discussion occurs on behalf of a specific patient

NOTE: 1. **HSCs** 08.19J and 08.19K may only be claimed by general practice physicians, generalists in Mental Health, pediatricians, psychiatrists, community medicine specialists and specialists in Mental Health.

2. **HSCs** 08.19J and 08.19K are to be claimed using the Personal Health Number of the patient, naming the personnel, agencies or organizations involved.

3. Each physician involved in a patient conference may claim for patient services using **HSC** 08.19J or 08.19K, per patient, to a maximum of 6 patients in a 30-minute period.

4. **HSC** 08.19K may be claimed when the physician most responsible for the patient's care has submitted a claim under HSC 08.19J.

5. HSC 08.19K may be claimed to a maximum of 2 calls per patient, per week, per physician.

SECTION OF INTERNAL MEDICINE

01.22 Other nonoperative colonoscopy
NOTE: 1. HSCs 13.99AE, 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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. Refer to HSCs 01.22A, 01.22B and 01.22C for screening.

01.22A Other nonoperative colonoscopy for screening of high risk patients
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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 for screening purposes for those patients that have been considered to be of high risk for colon cancer.
5. High risk is defined as an individual that has a strong family history of colorectal cancer with multiple individuals affected but no genetic syndrome identified family history of Hereditary Non-Polyposis Colorectal Cancer or a personal history of inflammatory bowel disease.
6. May be claimed once every year.

01.22B Other nonoperative colonoscopy for screening of moderate risk patients
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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 for screening purposes for those patients that have been considered to be of moderate risk for colon cancer.
5. Moderate risk is defined as an individual who has one or more first degree relatives with colorectal cancer or personal history of colorectal adenomatous polyps.
6. May be claimed once every 5 years.

01.22C Other nonoperative colonoscopy for screening of average risk patients
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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 for screening purposes for those patients that have been considered to be of average risk for colon cancer.
5. Average risk is defined as an individual that is asymptomatic and aged 50 to 74 years.
6. May be claimed once every 10 years.

01.24B Flexible proctosigmoidoscopy, diagnostic only
NOTE: 1. HSCs 13.99AE, 57.13A, 57.21A, 57.21B, 58.99C 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.

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 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.

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 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.

03.04M Pre-operative history and physical examination in relation to an insured service
NOTE: 1. May only be claimed when an examination and a standard form for pre-operative assessment have been completed.
2. A copy of the form must be retained in the patient's chart.
3. May not be claimed in addition to a surgical assist (SA, SAQS, SSOS) for the same patient by the same physician.
4. HSC 03.04M may not be claimed for a pre operative physical examination when the request is for a cataract procedure (HSC 27.72A) that will not require the use of a general anesthetic.

> ***AMA Billing Tip:*** The pre op for cataract procedures performed under local and or topical anesthetic is still required but will have to be completed by the operating surgeon. The only time the pre op medical (03.04M) will be paid in relation to cataract procedures, is if the patient is having their cataract performed under a general anesthetic. In those rare cases that require a general anesthetic, the operating surgeon will have to communicate the unique situation to the physician completing the pre op medical so that the information can be included in the text on the claim for the 03.04M pre op medical. If text is not submitted on the 03.04M for cataracts requiring a general anesthetic, the 03.04M will not be paid.

57.21A Polypectomy of large intestine, additional benefit
NOTE: **1. May only be claimed for the removal of polyps that are greater than 5mm in size.**
~~1~~**2**. May only be claimed with HSCs 01.16B, 01.16C, 01.22, 01.22A, 01.22B, 01.22C, **01.24B,** 01.24BA and 01.24BB and when the removal of a colonic mucosal lesion is performed using a polypectomy snare (with or without electrocautery)or a hot biopsy forceps.
3. May be claimed in addition to HSC 57.21C if polyps are removed from different sites.
4. May not be claimed when a regular biopsy forceps is used to remove a diminutive polyp without electrocautery, even if multiple passes are required.
5. Benefit includes placement of clips at the time of polypectomy.
6. Each additional polyp may be claimed at the rate specified on the Price List; a maximum benefit of six calls applies

X128 Bone mineral content determination dual photon absorptiometry with or without vertebral fracture assessment (VFA)
NOTE: 1. May only be claimed once every two years from the date of the last service.
2. For patients that are at high risk or have conditions that require more frequent assessments, text describing the circumstances will be required.
3. May only be claimed for patients 50 years of age or older unless the patient is referred by a Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

AMA Billing Tip: When ordering BMDs more frequently than once every two years, the ordering physician should make the providing physician aware of the specific need for more frequent tests. Claims for more frequent BMD's must be submitted with text that states the circumstances of the patient's condition, i.e. medication, illness. Please refer to the Fee Navigator for more information.

Other references and clinical indications for X128 ordering and performance are:

- Patient being monitored during a "bisphosphonate holiday"
- Patient on therapy in whom there are clinical features to question drug effect (i.e. fracture while on therapy)
- Patient is post transplant
- Patient has hyperparathyroidism
- Patient on supraphysiologic prednisone longer than 12 months

For patients that require a BMD prior to their 50th birthday, the request for the study will only be fulfilled if the request is made by one of the following specialties: Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

SECTION OF NEPHROLOGY

13.99A Hemodialysis treatment, unstable patient
For assessment and management of an unstable ~~patient with acute/chronic renal failure~~ **undergoing hemodialysis treatment where the physician attends and assesses or changes the treatment at the time of the visit**

> ***AMA Billing Note:*** The change in description clarifies that the physician must have a face-to-face visit with the patient in order to submit a claim for the service.

13.99B **Remove EV, NTAM, NTPM, and WK Surcharges**
Hemodialysis treatment, stable patient
for assessment and management of a stable patient with chronic renal failure
NOTE: May only be claimed when the patient is seen while receiving hemodialysis. If the patient is seen when they are not receiving hemodialysis, the appropriate visit HSC should be claimed.

13.99D **Remove EV, NTAM, NTPM, and WK Surcharges**
Assessment and management of a stable patient with chronic renal failure treated by peritoneal dialysis

X128 Bone mineral content determination dual photon absorptiometry with or without vertebral fracture assessment (VFA)
NOTE: 1. May only be claimed once every two years from the date of the last service.
2. For patients that are at high risk or have conditions that require more frequent assessments, text describing the circumstances will be required.
3. May only be claimed for patients 50 years of age or older unless the patient is referred by a Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

AMA Billing Tip: When ordering BMDs more frequently than once every two years, the ordering physician should make the providing physician aware of the specific need for more frequent tests. Claims for more frequent BMD's must be submitted with text that states the circumstances of the patient's condition, i.e. medication, illness. Please refer to the Fee Navigator for more information.

Other references and clinical indications for X128 ordering and performance are:

- Patient being monitored during a "bisphosphonate holiday"
- Patient on therapy in whom there are clinical features to question drug effect (i.e. fracture while on therapy)
- Patient is post transplant
- Patient has hyperparathyroidism
- Patient on supraphysiologic prednisone longer than 12 months

For patients that require a BMD prior to their 50th birthday, the request for the study will only be fulfilled if the request is made by one of the following specialties: Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

SECTION OF OBSTETRICS AND GYNECOLOGY

78.99B Other tubal sterilization, any method
NOTE: May not be claimed if sterilization is subsequent to a previous reversal. If a repeat procedure is required due to a previously failed attempt, supporting documentation must be provided.

> ***AMA Billing Tip:*** If a patient previously had an insured tubal sterilization followed by a reversal, the second tubal sterilization is not considered to be an insured service and should be billed to the patient.

80.19E Endometrial ablation by any non-hysteroscopic method (e.g. microwave, thermablate, etc.)
NOTE: **May not be claimed in addition** to HSC 80.81 ~~may be claimed in addition.~~

80.81 Hysteroscopy
NOTE: 1. Benefit includes biopsy.
2. May not be claimed **in addition to** ~~with~~ HSC**s** 80.19D **or 80.19E.**

SECTION OF OPHTHALMOLOGY

03.04M Pre-operative history and physical examination in relation to an insured service
NOTE: 1. May only be claimed when an examination and a standard form for pre-operative assessment have been completed.
2. A copy of the form must be retained in the patient's chart.
3. May not be claimed in addition to a surgical assist (SA, SAQS, SSOS) for the same patient by the same physician.
4. HSC 03.04M may not be claimed for a pre operative physical examination when the request is for a cataract procedure (HSC 27.72A) that will not require the use of a general anesthetic.

> ***AMA Billing Tip:*** The pre op for cataract procedures performed under local and or topical anesthetic is still required but will have to be completed by the operating surgeon. The only time the pre op medical (03.04M) will be paid in relation to cataract procedures, is if the patient is having their cataract performed under a general anesthetic. In those rare cases that require a general anesthetic, the operating surgeon will have to communicate the unique situation to the physician completing the pre op medical so that the information can be included in the text on the claim for the 03.04M pre op medical. If text is not submitted on the 03.04M for cataracts requiring a general anesthetic, the 03.04M will not be paid.

09.13E Optical coherence tomography (OCT), **for the diagnosis and management of ocular pathology**, interpretation
NOTE: May not be claimed for routine examinations or routine screening.

09.13F Optical coherence tomography (OCT), **for the diagnosis and management of ocular pathology,** technical
NOTE: May not be claimed for routine examinations or routine screening.

> ***AMA Billing Tip:*** The note on HSCs 09.13E and 09.13F distinguishes this service as one that is used for suspect glaucoma or to detect any changes in the nerve that is characteristic of glaucoma. This code should not be claimed for routine cataract evaluation; OCT for cataract is considered part of the initial work up for cataract evaluation.

21.71 Dacryocystorhinostomy (DCR)
NOTE: May not be claimed in addition to HSCs 33.01A, 33.51B, 33.76C, 34.54A and 34.89A.

28.54A Panretinal photocoagulation
NOTE: A maximum of 8 calls per patient per lifetime may be claimed.

33.01A Control of epistaxis by anterior nasal packing with or without cautery
NOTE**: 1.** Benefit includes visit.
2. May not be claimed in addition to HSC 21.71.

33.51B [Turbinectomy by diathermy or cryosurgery] Other methods
NOTE: **1.** Includes that with steroid injections.
2. May not be claimed in addition to HSC 21.71.

33.76C [Other rhinoplasty or septoplasty] Infracture
NOTE: May not be claimed in addition to HSC 21.71.

34.54A [Ethmoidectomy] Intranasal
NOTE: May not be claimed in addition to HSC 21.71.

34.89A Sinus endoscopy with polypectomy
NOTE: May not be claimed in addition to HSC 21.71.

SECTION OF ORTHOPEDICS

91.09A **Diaphyseal bone** ~~E~~**e**xternal fixation **with possible metaphyseal fixation** ~~long bone (humerus, radius, ulna, femur or tibia) or adjacent joint including closed reduction~~
NOTE: This will include complex cases such as a severe tibial plateau fracture that cannot be treated with internal fixation.

A**dded to GR 6.9.7e) to indicate that the surgical benefit is payable at 100% when billed in addition to another procedure.**

> ***AMA Billing Tip:*** 91.09A should NOT be used for wrist pinning; the new code 91.09B should be used for closed reduction and pinning of distal radius metaphyseal fractures.

91.09B **Closed reduction and pinning of distal radius metaphyseal fractures**

92.78B Facet joint in spine
NOTE: May not be claimed in addition to HSCs 16.89B, 16.89C or 16.89D.

92.78C **Contrast arthrogram**, ~~U~~**u**nspecified site
NOTE: May not be claimed in addition to HSCs 16.89B, 16.89C or 16.89D.

93.41A Total knee arthroplasty, including hemiarthroplasty
NOTE: **1**. May not be claimed in addition to HSC 92.45.
2. Benefit includes cancellous bone grafting of minor femoral and tibial cysts.

> ***AMA Billing Tip:*** Note 2 clarifies the services that are included in the total knee arthroplasty.

93.59A Total hip arthroplasty
NOTE: **1.** May not be claimed in addition to HSC 92.44.
2. Benefit includes screw placement in the acetabulum and bone grafting minor acetabular cysts.

> ***AMA Billing Tip:*** Note 2 clarifies the services that are included in the total hip arthroplasty.

96.12B Transmetatarsal
NOTE: 1. One call may be claimed per foot regardless of the number of metatarsals that are removed.
2. Two calls may only be claimed for bilateral procedures.

X128 Bone mineral content determination dual photon absorptiometry with or without vertebral fracture assessment (VFA)
NOTE: 1. May only be claimed once every two years from the date of the last service.
2. For patients that are at high risk or have conditions that require more frequent assessments, text describing the circumstances will be required.
3. May only be claimed for patients 50 years of age or older unless the patient is referred by a Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

AMA Billing Tip: When ordering BMDs more frequently than once every two years, the ordering physician should make the providing physician aware of the specific need for more frequent tests. Claims for more frequent BMD's must be submitted with text that states the circumstances of the patient's condition, i.e. medication, illness. Please refer to the Fee Navigator for more information.

Other references and clinical indications for X128 ordering and performance are:

- Patient being monitored during a "bisphosphonate holiday"
- Patient on therapy in whom there are clinical features to question drug effect (i.e. fracture while on therapy)
- Patient is post transplant
- Patient has hyperparathyroidism
- Patient on supraphysiologic prednisone longer than 12 months

For patients that require a BMD prior to their 50th birthday, the request for the study will only be fulfilled if the request is made by one of the following specialties: Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

SECTION OF OTOLARYNGOLOGY

21.71 Dacryocystorhinostomy (DCR)
NOTE: May not be claimed in addition to HSCs 33.01A, 33.51B, 33.76C, 34.54A and 34.89A.

33.01A Control of epistaxis by anterior nasal packing with or without cautery
NOTE**: 1.** Benefit includes visit.
2. May not be claimed in addition to HSC 21.71.

33.51B [Turbinectomy by diathermy or cryosurgery] Other methods
NOTE: **1.** Includes that with steroid injections.
2. May not be claimed in addition to HSC 21.71.

33.76C [Other rhinoplasty or septoplasty] Infracture
NOTE: May not be claimed in addition to HSC 21.71.

34.54A [Ethmoidectomy] Intranasal
NOTE: May not be claimed in addition to HSC 21.71.

34.89A Sinus endoscopy with polypectomy
NOTE: May not be claimed in addition to HSC 21.71.

SECTION OF PEDIATRICS

01.22 Other nonoperative colonoscopy
NOTE: 1. HSCs 13.99AE, 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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. Refer to HSCs 01.22A, 01.22B and 01.22C for screening.

01.22A Other nonoperative colonoscopy for screening of high risk patients
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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 for screening purposes for those patients that have been considered to be of high risk for colon cancer.
5. High risk is defined as an individual that has a strong family history of colorectal cancer with multiple individuals affected but no genetic syndrome identified family history of Hereditary Non-Polyposis Colorectal Cancer or a personal history of inflammatory bowel disease.
6. May be claimed once every year.

01.22B Other nonoperative colonoscopy for screening of moderate risk patients
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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 for screening purposes for those patients that have been considered to be of moderate risk for colon cancer.
5. Moderate risk is defined as an individual who has one or more first degree relatives with colorectal cancer or personal history of colorectal adenomatous polyps.
6. May be claimed once every 5 years.

01.22C Other nonoperative colonoscopy for screening of average risk patients
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C 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 for screening purposes for those patients that have been considered to be of average risk for colon cancer.
5. Average risk is defined as an individual that is asymptomatic and aged 50 to 74 years.
6. May be claimed once every 10 years.

01.24B Flexible proctosigmoidoscopy, diagnostic only
NOTE: 1. HSCs 13.99AE, 57.13A, 57.21A, 57.21B, 58.99C 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.

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 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.

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 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.

03.05JJ Professional communication/, ~~case conference or~~ discussion with allied health professionals, educational or other community agencies on behalf of a specific patient, full 5 minutes or major portion thereof for the first call when only one call is claimed
NOTE: 1. May only be claimed by:
- pediatricians (including subspecialties) for patients 18 years of age and under;
- medical geneticists (no age restriction).
2. May only be claimed:
- when the communication is initiated by the allied health, educational or community agency;
- for services related to school difficulties, learning disorders, behavioural problems, psychiatric disorders, developmental disorders, major chronic disease, pre-transplant donor/recipient assessment, multiple handicap disorders, child abuse or neglect.
3. May be claimed:
- for communication provided in person, by telephone or other telecommunication methods;
- in addition to visits or other services provided on the same day by the same physician.
4. A maximum benefit of 60 minutes or 12 calls per physician, per week, applies.
5. This service is to be claimed using the Personal Health Number of the patient.
6. Documentation of the communication must be recorded in the patient record.

AMA Billing Tip: The removal of "*case conference*" from 03.05JJ is intended to clarify that this service is not billable for case conferences. Case conferences should be billed using the most appropriate conference code.

08.19K Second and subsequent physician attendance at a formal, scheduled, professional conference related to the care and treatment of multiple psychiatric patients, when discussion occurs on behalf of a specific patient
NOTE: 1. **HSCs** 08.19J and 08.19K may only be claimed by general practice physicians, generalists in Mental Health, pediatricians, psychiatrists, community medicine specialists and specialists in Mental Health.
2. **HSCs** 08.19J and 08.19K are to be claimed using the Personal Health Number of the patient, naming the personnel, agencies or organizations involved.
3. Each physician involved in a patient conference may claim for patient services using **HSC** 08.19J or 08.19K, per patient, to a maximum of 6 patients in a 30-minute period.
4. **HSC** 08.19K may be claimed when the physician most responsible for the patient's care has submitted a claim under HSC 08.19J.
5. HSC 08.19K may be claimed to a maximum of 2 calls per patient, per week, per physician.

57.21A Polypectomy of large intestine, additional benefit
NOTE: **1. May only be claimed for the removal of polyps that are greater than 5mm in size.**
2. May only be claimed with HSCs 01.16B, 01.16C, 01.22, 01.22A, 01.22B, 01.22C, **01.24B**, 01.24BA and 01.24BB and when the removal of a colonic mucosal lesion is performed using a polypectomy snare (with or without electrocautery)or a hot biopsy forceps.
3. May be claimed in addition to HSC 57.21C if polyps are removed from different sites.
4May not be claimed when a regular biopsy forceps is used to remove a diminutive polyp without electrocautery, even if multiple passes are required.
5. Benefit includes placement of clips at the time of polypectomy.
6. Each additional polyp may be claimed at the rate specified on the Price List; a maximum benefit of six calls applies.

X313A Ultrasound, inguinal hernia
NOTE: 1. May only be claimed when the referral is supplied by a urologist (UROL) or general surgeon (GNSG). For pediatric patients, a general practitioner (GP), pediatrician (PED), urologist (UROL) or pediatric general surgeon (PDSG) may also make referrals.

> ***AMA Billing Note:*** Minimally symptomatic hernias do not necessarily require an ultrasound.
> If the inguinal hernia is likely surgical or symptomatic, the appropriate referral should be made, the surgical specialist will determine if an ultrasound is necessary.

X128 Bone mineral content determination dual photon absorptiometry with or without vertebral fracture assessment (VFA)
NOTE: 1. May only be claimed once every two years from the date of the last service.
2. For patients that are at high risk or have conditions that require more frequent assessments, text describing the circumstances will be required.
3. May only be claimed for patients 50 years of age or older unless the patient is referred by a Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

AMA Billing Tip: When ordering BMDs more frequently than once every two years, the ordering physician should make the providing physician aware of the specific need for more frequent tests. Claims for more frequent BMD's must be submitted with text that states the circumstances of the patient's condition, i.e. medication, illness. Please refer to the Fee Navigator for more information.

Other references and clinical indications for X128 ordering and performance are:

- Patient being monitored during a "bisphosphonate holiday"
- Patient on therapy in whom there are clinical features to question drug effect (i.e. fracture while on therapy)
- Patient is post transplant
- Patient has hyperparathyroidism
- Patient on supraphysiologic prednisone longer than 12 months

For patients that require a BMD prior to their 50th birthday, the request for the study will only be fulfilled if the request is made by one of the following specialties: Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

SECTION OF PHYSICAL MEDICINE AND REHABILITATION

16.89D Percutaneous facet joint injection - Lumbar/Sacral
NOTE: 1. A maximum of four calls may be made per patient, per day regardless of level (HSCs 16.89B, 16.89C or 16.89D).
2. A maximum of twelve calls may be claimed per patient, per benefit year regardless of level (HSCs 16.89B, 16.89C or 16.89D).
3. HSCs 16.89B, 16.89C and 16.89D may not be claimed in addition to HSCs 13.59B, 13.59J, 92.78B or 92.78C.
4. HSCs X 55 or X 56 may only be claimed in addition to HSCs 16.89B, 16.89C or 16.89D once per year, per patient.

X128 Bone mineral content determination dual photon absorptiometry with or without vertebral fracture assessment (VFA)
NOTE: 1. May only be claimed once every two years from the date of the last service.
2. For patients that are at high risk or have conditions that require more frequent assessments, text describing the circumstances will be required.
3. May only be claimed for patients 50 years of age or older unless the patient is referred by a Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

AMA Billing Tip: When ordering BMDs more frequently than once every two years, the ordering physician should make the providing physician aware of the specific need for more frequent tests. Claims for more frequent BMD's must be submitted with text that states the circumstances of the patient's condition, i.e. medication, illness. Please refer to the Fee Navigator for more information.

Other references and clinical indications for X128 ordering and performance are:

- Patient being monitored during a "bisphosphonate holiday"
- Patient on therapy in whom there are clinical features to question drug effect (i.e. fracture while on therapy)
- Patient is post transplant
- Patient has hyperparathyroidism
- Patient on supraphysiologic prednisone longer than 12 months

For patients that require a BMD prior to their 50th birthday, the request for the study will only be fulfilled if the request is made by one of the following specialties: Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

SECTION OF PLASTIC SURGERY

97.29A Simple mastectomy, **includes that for gynecomastia**
NOTE: 1. ~~Includes that for gynecomastia~~ **May only be claimed for:**
-pediatric gynecomastia (i.e. below the age of 18),
-symptomatic gynecomastia such as breast pain,
-prophylactic mastectomies for patients who are breast cancer gene positive or have a strong family history of breast cancer.
2. For cases other than those involving malignancies.

97.31 Unilateral reduction mammoplasty
NOTE: 1. May only be claimed if mammary hypertrophy is causing physical symptoms including, but not limited to back pain, shoulder pain or paresthesias of the arms.
2. Except in unusual circumstances, the expected weight of breast tissue to be removed should be in excess of 300g.
3. May be billed if being done as a 'balancing procedure' such as to compensate for breast changes in the contralateral breast due to breast cancer treatment or to correct gross congenital/developmental asymmetry.

98.12H Excision of soft tissue tumor(s) (subcutaneous) full 30 minutes of operating time or **major** portion thereof for the first call when only one call is claimed
NOTE: 1. For sebaceous cyst removal see HSC 98.12C.
2. After the first full 30 minutes has elapsed, each subsequent 15 minutes or **major** portion thereof, is payable at the rate specified in the Price List; a maximum benefit applies.

SECTION OF PSYCHIATRY

08.19K Second and subsequent physician attendance at a formal, scheduled, professional conference related to the care and treatment of multiple psychiatric patients, when discussion occurs on behalf of a specific patient

NOTE: 1. **HSCs** 08.19J and 08.19K may only be claimed by general practice physicians, generalists in Mental Health, pediatricians, psychiatrists, community medicine specialists and specialists in Mental Health.

2. **HSCs** 08.19J and 08.19K are to be claimed using the Personal Health Number of the patient, naming the personnel, agencies or organizations involved.

3. Each physician involved in a patient conference may claim for patient services using **HSC** 08.19J or 08.19K, per patient, to a maximum of 6 patients in a 30-minute period.

4. **HSC** 08.19K may be claimed when the physician most responsible for the patient's care has submitted a claim under HSC 08.19J.

5. HSC 08.19K may be claimed to a maximum of 2 calls per patient, per week, per physician.

SECTION OF RHEUMATOLOGY

X128 Bone mineral content determination dual photon absorptiometry with or without vertebral fracture assessment (VFA)

NOTE: 1. May only be claimed once every two years from the date of the last service.

2. For patients that are at high risk or have conditions that require more frequent assessments, text describing the circumstances will be required.

3. May only be claimed for patients 50 years of age or older unless the patient is referred by a Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

AMA Billing Tip: When ordering BMDs more frequently than once every two years, the ordering physician should make the providing physician aware of the specific need for more frequent tests. Claims for more frequent BMD's must be submitted with text that states the circumstances of the patient's condition, i.e. medication, illness. Please refer to the Fee Navigator for more information.

Other references and clinical indications for X128 ordering and performance are:

- Patient being monitored during a "bisphosphonate holiday"
- Patient on therapy in whom there are clinical features to question drug effect (i.e. fracture while on therapy)
- Patient is post transplant
- Patient has hyperparathyroidism
- Patient on supraphysiologic prednisone longer than 12 months

For patients that require a BMD prior to their 50th birthday, the request for the study will only be fulfilled if the request is made by one of the following specialties: Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.

SECTION OF UROLOGY

75.64 Vasectomy (complete) (partial)
NOTE: May not be claimed if vasectomy is subsequent to a previous reversal. If a repeat procedure is required due to a previously failed attempt, supporting documentation must be provided.

> ***AMA Billing Tip:*** If a patient previously had an insured vasectomy followed by a reversal, the second vasectomy is not considered to be an insured service and should be billed to the patient.

X313A Ultrasound, inguinal hernia
NOTE: 1. May only be claimed when the referral is supplied by a urologist (UROL) or general surgeon (GNSG). For pediatric patients, a general practitioner (GP), pediatrician (PED), urologist (UROL) or pediatric general surgeon (PDSG) may also make referrals.

> ***AMA Billing Note:*** Minimally symptomatic hernias do not necessarily require an ultrasound.
> If the inguinal hernia is likely surgical or symptomatic, the appropriate referral should be made, the surgical specialist will determine if an ultrasound is necessary.