Billing Corner

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Billing Corner is also available on the Alberta Medical Association website
http://bit.ly/1oNj9im

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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.

***Electronic copy**:*

***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 January 1, 2017

SCHEDULE OF MEDICAL BENEFIT CHANGES

(Note: Wording in **bold** indicates changes)

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CHANGES IMPACTING ALL PHYSICIANS

G.R. 2.3.7 Concurrent billing for overlapping time for separate patient encounters/services may not be claimed.

AMA Billing Tip: *G.R. 2.3.7 indicates that a physician may not submit two claims for services for the same time period.*

For example, the physician examines the patient for 15 minutes and provides a minor procedure (wart removal 98.12L) at the same visit, the total time spent with the patient is 35 minutes. The physician may submit a claim for the:

visit 03.03A + CMGP01 or CMXV15 (as appropriate) for the visit portion
and *the minor procedure 98.12L*

Time spent providing the procedure cannot be submitted using complex modifiers when a claim for BOTH the procedure and the visit are submitted.

G.R. 4.6.1 Comprehensive visits and/or comprehensive/major consultations may only be claimed once every ~~180~~ **365** days per patient by the same physician. Comprehensive visit and consultation services are defined as HSCs 03.04A, 03.**08A, 03.08B, 03.08C, 03.08F, 03.08H, 03.08K**, ~~series 03.09B~~, 08.11A, 08.11C, 08.19A and 08.19AA. ~~There must be an interval of 180 days between the first and second comprehensive services.~~

HSC 03.09B is defined as comprehensive and may not be billed more frequently than once every 180 days by the same physician.

HSCs 03.04O and 03.04P are defined as comprehensive services and may not be billed more frequently than four times per year as indicated or within 180 days of a comprehensive service or consultation by the same physician.

AMA Billing Tip: *For comprehensive services billed prior to January 1, the 365 day rule will be effective starting from the day after the last comprehensive.*

For example, if the patient had a comprehensive December 13th, 2016, the next comprehensive by the same physician is not technically eligible until December 14th of 2017.

Alberta Health has relaxed the system rules to 345 days, be advised that this adjustment to the payment processing rules is intended to accommodate a small variance in patient/physician schedules; and not as permission to bill a comprehensive more frequently.

G.R. 13.5 Consultation benefits (HSCs 03.08A or 03.07A) or preoperative assessments (HSC 03.04M) may not be claimed in addition to a surgical assist (SA, SAQS, SSOS) for the same patient by the same physician.

03.05S **DELETE HSC**
03.05S Special call to office

NOTE: 1. When a physician must travel to his/her office which is closed, with no staff in attendance.
2. Subsequent patients seen may be claimed under code 03.02A, 03.03A, 03.04A or the appropriate procedural code.

03.03ME Special call to closed office, weekdays (0000-2400)
NOTE: 1. When a physician must travel to his/her office which is closed, with no staff in attendance.
2. A maximum of five (5) per weekday, per physician may be claimed.
3. Subsequent patients seen may be claimed under code 03.02A, 03.03A, 03.04A or the appropriate procedural code.

03.03MF Special call to closed office, weekends and statutory holidays (0000-2400)
NOTE: 1. When a physician must travel to his/her office which is closed, with no staff in attendance.
2. A maximum of ten (10) per weekend day or statutory holiday, per physician may be claimed.
3. Subsequent patients seen may be claimed under code 03.02A, 03.03A, 03.04A or the appropriate procedural code.

G.R. 15.11.7 A maximum of five (5) special callbacks to a closed office, HSC 03.03ME, may be claimed, per physician, in any given weekday, Monday - Friday (0000 - 2400 hours).

G.R. 15.11.8 A maximum of ten (10) special callbacks to a closed office, HSC 03.03MF may be claimed, per physician, on any day of the weekend or statutory holiday, (0000 - 2400 hours).

AMA Billing Tip: *The callback to closed office (HSC 03.05S) will be deleted and replaced with HSCs 03.03ME and 03.03MF. These codes are limited by time of day as are other callback codes. The second and subsequent patient seen at the same callback should be claimed as the appropriate visit service i.e. 03.02A, 03.03A etc.*

G.R. 18.1 The Body Mass Index (BMI) modifier may be claimed for selected procedures, obstetrical services, anesthesia, second qualified surgeon and surgical assistant services provided in any location when the following criteria are met:
a) An adult patient has a body mass index of ~~35~~ **40** or more.
b) A patient under 18 years of age who is above the 97th percentile for BMI on an approved pediatric growth curve.
c) The following HSCs are only eligible for the BMI modifier when the service is provided under general, spinal, epidural anesthetic or regional nerve block performed in an operating room, day surgery or surgical suite:
98.11A, 98.11B, 98.11C, 98.11D, 98.11E, 98.11F, 98.22A, 98.22B.

AMA Billing Tip: *The change to BMI of 40 affects the* ***adult population ONLY****. There HAVE NOT been any changes to the pediatric criteria for BMI.*

BMI of 40 applies to all procedures and services including the complex care plan (03.04J) for General Practitioners.

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.

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

03.08A Comprehensive consultation
NOTE: May not be claimed in addition to a surgical assist (SA, SAQS, SSOS) for the same patient by the same physician.

98.22B Laceration, face, over 2.5 cms (1 unit) and/or body, over 5 cms (1 unit)
For each layer or unit, refer to Price List
NOTE: The following applies to HSCs 98.22A and 98.22B.
1. Benefit includes primary closure of wound by any method excluding adhesive tape skin closure or simple bandaging, normal wound care follow-up and suture removal.
2. Where the laceration is treated with the use of adhesive tape skin closure or simple bandaging, a visit should be claimed.
3. Where multiple lacerations are repaired, use the combined length.
4. May only be claimed when the laceration is a result of a trauma either minor or major.
5. May not be claimed in addition to an elective procedure.

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.

SECTION OF ANESTHESIA

17.32A Facial nerve decompression
NOTE: May not be claimed in addition to HSCs 52.31A, 52.31B, 52.31C or 52.31D by the same or different physician at the same encounter.

17.33 Release of carpal tunnel
NOTE: May not be claimed in addition to HSC 17.39C.

17.39B Major nerve exploration
NOTE: 1. May not be claimed for the release of carpal tunnel (HSC 17.33) or procedures/diagnostic conditions related to carpal tunnel.
2. May not be claimed in addition to HSC 17.39C.

17.39C Release ulnar nerve (includes transposition)
NOTE: May not be claimed with **HSCs** 17.5 A, **17.33 or 17.39B.**

SECTION OF DIAGNOSTIC IMAGING

13.59H Local infiltration of tissue
NOTE: May not be claimed with ~~17.71A~~ **any other procedure at the same encounter by the same or different physician.**

X43 Knee
NOTE: May not be claimed in addition to HSCs X54A and X54B.

X47 Hip
NOTE: May not be claimed in addition to HSCs X54A and X54B.

X51 Pelvis
NOTE: May not be claimed in addition to HSCs X54A and X54B.

X52 Pelvis and one hip
NOTE: May not be claimed in addition to HSCs X54A and X54B.

X53 Pelvis and both hips
NOTE: May not be claimed in addition to HSCs X54A and X54B.

X54 Sacro-iliac joints
NOTE: May not be claimed in addition to HSCs X54A and X54B.

X55 One area
NOTE: May not be claimed in addition to HSCs X54A and X54B.

X56 One area – with obliques
NOTE: May not be claimed in addition to HSCs X54A and X54B.

X57 Two areas
NOTE: May not be claimed in addition to HSCs X54A and X54B.

X57A Two areas (of the spine) with obliques of each area
NOTE: May not be claimed in addition to HSCs X54A and X54B.

X58 Complete spine
NOTE: May not be claimed in addition to HSCs X54A and X54B.

X58A - flexion and extension
NOTE: May not be claimed in addition to HSCs X54A and X54B.

X58B - lateral bending
NOTE: May not be claimed in addition to HSCs X54A and X54B.

X58E More than two areas (of the spine) with obliques of each area
NOTE: May not be claimed in addition to HSCs X54A and X54B.

X59 Lumbo sacral spine and pelvis
NOTE: May not be claimed in addition to HSCs X54A and X54B.

X60 Lumbo sacral spine and sacro-iliac joints
NOTE: May not be claimed in addition to HSC's X54A and X54B.

X61 Lumbo sacral spine and pelvis and sacro-iliac joints
NOTE: May not be claimed in addition to HSC's X54A and X54B.

X62 Lumbo sacral spine and one hip
NOTE: May not be claimed in addition to HSC's X54A and X54B.

X63 Lumbo sacral spine and both hips
NOTE: May not be claimed in addition to HSCs X54A and X54B.

X64 Lumbo sacral spine, pelvis and one hip
NOTE: May not be claimed in addition to HSCs X54A and X54B.

X65 Lumbo sacral spine, pelvis and both hips
NOTE: May not be claimed in addition to HSCs X54A and X54B.

X54A Stress views of a limb
Additional benefit
X 54A - unilateral
NOTE: Refer to the note following HSC X 54B.

X54B X 54B – bilateral
NOTE: HSCs X 54A and X 54B may not be claimed in addition to HSCs X 43, X 47, X 51, X 52, X 53, X 54, X 55, X 56, X 57, X 57A, X 58, X 58A, X 58B, X 58D, X 58E, X 59, X 60, X 61, X 62, X 63, X 64, and X 65.

X58D ~~both~~ **flexion, extension and lateral bending**
NOTE: 1. HSCs X 58A, X 58B and X 58D may not be claimed in addition to HSCs X 54A and X 54B.
2. **HSCs** ~~Codes~~ X58A, X58B and X58D may be claimed in addition to **HSCs** X55, X56, X57, X57A, X58 and X58E.

X308 Ultrasound, breast, **including axilla**
NOTE: **1.** Two calls may only be claimed for bilateral ultrasound.
2. May not be claimed with HSC X309.

X309 Ultrasound, axilla
NOTE: **1**. Two calls may only be claimed for bilateral ultrasound.
2. May not be claimed with HSC X308.

AMA Billing Tip: *BIRADS 4 or 5 with a confirmed lesion where the breast and the axilla are completely examined may be submitted as X308 and X309 with text to Alberta Health for review. Text is only required on the X309.*

X310 Ultrasound, abdominal, complete or at least two abdominal organs
NOTE: May not be claimed in addition to HSC**s X311** and X312.

X311 Ultrasound, kidneys, ureters and bladder
NOTE: 1. Benefit includes any pre-void, post-void and/or jets.
2. May not be claimed in addition to HSCs **X310**, X316 and X328.

X334 Ultrasound, other than shoulder including joints, tendons, ligaments, muscles, single anatomic site
NOTE: **1**. A maximum of two anatomical areas may be claimed per patient, per physician, per day.
2. May not be claimed in addition to HSC X337.

X335 Ultrasound shoulder, dedicated rotator cuff and bicep
NOTE: **1.** Two calls may only be claimed for bilateral ultrasound.
2. May not be claimed in addition to HSC X337.

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, X323, X330, X331, X332, and X333, **X334 and X335** when services are provided by the same or different physician in the same facility on the same day.

SECTION OF GENERAL PRACTICE

03.04B Initial prenatal visit requiring complete history and physical examination
NOTE: 1. May not be charged within 90 days of another comprehensive visit or consultation.
2. May **only** be claimed once per pregnancy, ~~per physician.~~
3. Includes a full history, examination, initiation of the prenatal record and advice to the patient.

AMA Billing Tip: *This service* ***may only be claimed once per pregnancy per patient.*** *In the event the pregnancy is not viable and the patient becomes pregnant again within 180 days of the previous 03.04B, text may be required to explain the situation in order to obtain payment for the second 03.04B.*

All criteria in Note 3 must be met in order to submit a claim for the service.

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

NOTE: 1. **A maximum of 15 comprehensive annual care plans per physician per calendar week may be claimed.**

~~1~~**2**. May only be claimed by the most responsible primary care general practitioner.

~~2~~**3**. May only be claimed once per patient per year and includes ongoing communication as required as well as re-evaluation and revision of the plan within a year.

~~3~~**4**. May be claimed in addition to HSCs 03.03A, 03.03N or 03.04A.

~~4~~**5**. Time spent on the preparation of the complex care plan may not be included in he time requirement for a complex modifier.

~~5~~**6**. "Complex needs" means a patient with multiple complex health needs including chronic disease(s) and other complications. The patient must have at least two or more diagnoses from group A or one diagnosis from group A and one or more from group B in order to be eligible.

Group A	Group B
-Hypertensive Disease	-Mental Health Issues
-Diabetes Mellitus	-Obesity (Adult = BMI ~~35~~**40** or greater Child = 97 percentile)
-Chronic Obstructive Pulmonary Disease	
-Asthma	-Addictions
-Heart Failure	-Tobacco
-Ischemic Heart Disease	
-Chronic Renal Failure	

~~6~~**7**. "Care plan" means a single document that meets the following criteria:

a) Must be communicated through direct contact with the patient and/or the patient's agent.

b) Must include clearly defined goals which are mutually agreed upon between the patient and/or the patient's agent and the physician.

c) Must include a detailed review of the patient chart, current therapies, problem list and past medical history.

d) Must include any relevant information that may affect the patient's health or treatment options, such as demographics (education, income, language) or lifestyle behaviors (addictions, exercise, sleep habits, etc.)

e) Must incorporate the patient's values and personal health goals in the care plan, with respect to his or her complex needs.

f) Must outline expected outcomes as a result of this plan, including end-of-life issues when clinically appropriate.

g) Must identify other health care professionals that would be involved in the care of the patient and their expected roles.

h) Must include confirmation that the care plan has been communicated verbally and in writing to the patient and/or the patient's agent.

i) Must be signed by the physician and the patient or patient's agent.

j) Must be retained in the patient's medical record.

13.99BA **Periodic Papanicolaou Smear for patients between the ages of 21 and 69**
NOTE: 1. Two Papanicolaou smears may be claimed per patient, per physician, per year (April 1 of one year to March 31 of the following year). Additional claims may be submitted with supporting information.
2. May be claimed in addition to a visit or consultation.
3. When clinically indicated, Papanicolaou smears may be claimed for those patients not meeting the age requirements. In those instances, text must be submitted explaining the specific circumstance.
4. May not be claimed at the same encounter as HSC 13.99BD or 13.99BE.

***AMA Billing Tip**: The changes to the pap smear code were made to bring the fee codes in line with the Alberta Cervical Cancer Screening Clinical Practice Guidelines.*

13.99BC **DELETE HSC**
Pelvic examination using a speculum requiring swab(s) and/or sample(s) collection; and/or Periodic Papanicolaou Smear
NOTE: 1. Two Papanicolaou smears may be claimed per patient, per physician, per year (April 1 of one year to March 31 of the following year). Additional claims may be submitted with supporting information.
2. May be claimed with a visit or consultation.
3. May not be claimed at the same encounter as HSC 13.99BD.

13.99BD Anal Papanicolaou Smear
NOTE: 1. Two Anal Papanicolaou smears may be claimed per patient, per physician, per year (April 1 of one year to March 31 of the following year). Additional claims may be submitted with supporting information.
2. May be claimed ~~with~~ **in addition to** a visit or consultation.
3. May not be claimed at the same encounter as HSC ~~13.99BC~~ **13.99BA or 13.99BE**.

13.99BE **Pelvic examination using a speculum requiring swab(s) and/or sample(s) collection**
NOTE: 1. May be claimed with a visit or consultation.
2. May not be claimed at the same encounter as HSC 13.99BA or 13.99BD.

17.33 Release of carpal tunnel
NOTE: May not be claimed in addition to HSC 17.39C.

17.39B Major nerve exploration
NOTE: 1. May not be claimed for the release of carpal tunnel (HSC 17.33) or procedures/diagnostic conditions related to carpal tunnel.
2. May not be claimed in addition to HSC 17.39C.

17.39C Release ulnar nerve (includes transposition)
NOTE: May not be claimed with **HSCs** 17.5 A, **17.33 or 17.39B.**

SECTION OF GENERALISTS IN MENTAL HEALTH

08.11A Requiring complete mental status examination and investigation, first full 45 minutes or major portion thereof for the first call when only one call is claimed
NOTE: 1. May only be claimed for the initial visit.
2. When visit does not require complete examination and investigation, the appropriate office visit HSC should be claimed.
3. HSCs 08.19GA or 08.19GB may not be claimed at the same encounter. The total time spent providing the non-referred first visit must be claimed using the applicable non-referred first visit code.

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

08.19B Minor psychiatric consultation, full 15 minutes or major portion thereof for the first call when only one call is claimed.
NOTE: HSCs 08.19GA or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.

08.19C Repeat psychiatric consultation, per full 30 minutes or major portion thereof for the first call when only one call is claimed
NOTE: HSCs 08.19GA or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.

08.19GA Direct contact with a patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or psychiatric counseling, per 15 minutes or major portion thereof
NOTE: 1. May only be claimed by a psychiatrist (PSYC), a generalist in Mental Health (GNMH) or by a specialist in Mental Health (SPMH) if the intent of the session is the therapy of one individual patient, whether or not more than one person is involved in the session.
2. May be claimed for both referred and non-referred patients with psychiatric disorders.
3. May not be claimed at the same encounter as HSCs 08.11A, 08.11C, 08.19A, 08.19AA, 08.19B, 08.19BB, 08.19C or 08.19CC.

08.19GB Direct contact with a complex patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or psychiatric counseling, per 15 minutes or major portion thereof
NOTE: 1. May only be claimed by a psychiatrist or a generalist in mental health.
2. May only be claimed when the patient meets the criteria outlined in note 3 and the score is identified in the patient's chart at least once every six months.
3. Complex patient is defined as:
a. An adult with a Global Assessment of Function (GAF) score of 40 or less.
b. A child with a Children's Global Assessment of Function (CGAS) score of 41 or less.
4. May not be claimed at the same encounter as HSCs 08.11A, 08.11C, 08.19A, 08.19AA, 08.19B, 08.19BB, 08.19C or 08.19CC.

SECTION OF GENERAL SURGERY

17.33 Release of carpal tunnel
NOTE: May not be claimed in addition to HSC 17.39C.

17.39B Major nerve exploration
NOTE: 1. May not be claimed for the release of carpal tunnel (HSC 17.33) or procedures/diagnostic conditions related to carpal tunnel.
2. May not be claimed in addition to HSC 17.39C.

17.39C Release ulnar nerve (includes transposition)
NOTE: May not be claimed with **HSCs** 17.5 A, **17.33 or 17.39B.**

SECTION OF OBSTETRICS AND GYNECOLOGY

03.04B Initial ~~pre-natal~~ **prenatal** visit requiring complete history and physical examination
NOTE: 1. May not be charged within 90 days of another comprehensive visit or consultation.
2. May **only** be claimed once per pregnancy, ~~per physician.~~
3. Includes a full history, examination, initiation of the prenatal record and advice to the patient.

AMA Billing Tip: *This service* ***may only be claimed once per pregnancy per patient*** *In the event the pregnancy is not viable and the patient becomes pregnant again within 180 days of the previous 03.04B, text may be required to explain the situation in order to obtain payment for the second 03.04B.*

All criteria in Note 3 must be met in order to submit a claim for the service.

13.99BA Periodic Papanicolaou Smear for patients between the ages of 21 and 69
NOTE: 1. Two Papanicolaou smears may be claimed per patient, per physician, per year (April 1 of one year to March 31 of the following year). Additional claims may be submitted with supporting information.
2. May be claimed in addition to a visit or consultation.
3. When clinically indicated, Papanicolaou smears may be claimed for those patients not meeting the age requirements. In those instances, text must be submitted explaining the specific circumstance.
4. May not be claimed at the same encounter as HSC 13.99BD or 13.99BE.

13.99BC **DELETE HSC**
Pelvic examination using a speculum requiring swab(s) and/or sample(s) collection; and/or Periodic Papanicolaou Smear
NOTE: 1. Two Papanicolaou smears may be claimed per patient, per physician, per year (April 1 of one year to March 31 of the following year). Additional claims may be submitted with supporting information.
2. May be claimed with a visit or consultation.
3. May not be claimed at the same encounter as HSC 13.99BD.

13.99BD Anal Papanicolaou Smear
NOTE: 1. Two Anal Papanicolaou smears may be claimed per patient, per physician, per year (April 1 of one year to March 31 of the following year). Additional claims may be submitted with supporting information.
2. May be claimed ~~with~~ **in addition to** a visit or consultation.
3. May not be claimed at the same encounter as HSC ~~13.99BC~~ **13.99BA or 13.99BE**.

13.99BE Pelvic examination using a speculum requiring swab(s) and/or sample(s) collection
NOTE: 1. May be claimed with a visit or consultation.
2. May not be claimed at the same encounter as HSC 13.99BA or 13.99BD.

AMA Billing Tip: *The changes to the pap smear code were made to bring the fee codes in line with the Alberta Cervical Cancer Screening Clinical Practice Guidelines.*

SECTION OF ORTHOPEDICS

17.33 Release of carpal tunnel
NOTE: May not be claimed in addition to HSC 17.39C.

17.39B Major nerve exploration
NOTE: 1. May not be claimed for the release of carpal tunnel (HSC 17.33) or procedures/diagnostic conditions related to carpal tunnel.
2. May not be claimed in addition to HSC 17.39C.

17.39C Release ulnar nerve (includes transposition)
NOTE: May not be claimed with **HSCs** 17.5 A, **17.33 or 17.39B.**

92.40 Synovectomy, shoulder
NOTE: May not be claimed in addition to HSCs 93.81A, 93.81B or 93.96E.

92.41 Synovectomy, elbow
NOTE: May not be claimed in addition to HSCs 93.96D or 93.96E.

92.42 Synovectomy, wrist
NOTE: May not be claimed in addition to HSCs 93.87C, 93.96D or 93.96E.

92.44 Synovectomy, hip
NOTE: May not be claimed in addition to HSCs 93.59A, 93.69B, 93.69C or 93.96E.

92.45 Synovectomy, knee
NOTE: May not be claimed in addition to HSCs 93.41A or 93.96E.

92.46 Synovectomy, ankle
NOTE: May not be claimed in addition to HSCs 93.96D or 93.96E.

93.41A Total knee arthroplasty, including hemiarthroplasty
NOTE: May not be claimed in addition to HSC 92.45.

93.59A Total hip arthroplasty
NOTE: May not be claimed in addition to HSC 92.44.

93.69B Hemiarthroplasty hip with uncemented prosthesis
NOTE: May not be claimed in addition to HSC 92.44.

93.69C Hemiarthroplasty hip with cemented prosthesis
NOTE: May not be claimed in addition to HSC 92.44.

93.81A Total joint arthroplasty of shoulder (glenoid and humeral replacement)
NOTE: May not be claimed in addition to HSC 92.40.

93.81B Hemiarthroplasty of shoulder with synthetic prosthesis
NOTE: May not be claimed with **HSCs 92.40**, 93.83D, 95.65B, 93.83H or 91.30H.

93.87C Total arthroplasty of wrist using synthetic prosthesis
NOTE: May not be claimed in addition to HSCs 92.42.

93.96D Primary total joint arthroplasty (ankle, elbow, wrist)
NOTE: May not be claimed in addition to HSCs 92.41, 92.42 or 92.46.

93.96E Primary total joint arthroplasty with major reconstruction including structural allograft, protrusio ring/custom implant (hip, knee, ankle, shoulder, elbow, wrist)
NOTE: May not be claimed in addition to HSCs 92.40, 92.41, 92.42, 92.44, 92.45 or 92.46.

SECTION OF OTOLARYNGOLOGY

17.32A Facial nerve decompression
NOTE: May not be claimed in addition to HSCs 52.31A, 52.31B, 52.31C or 52.31D by the same or different physician at the same encounter.

98.51E Free flaps involving microsurgical technique and neuro-vascular hook-up, **for** head and neck reconstruction, **or for procedures related to head and neck reconstruction**, full 60 minutes or major portion thereof for the first call when only one call is claimed
NOTE: The total time claimed for HSC 98.51E may only reflect the time spent providing micro surgery and may not include time spent providing other services.

17.71A Local block(s) of somatic nerve(s)
NOTE: May not be claimed with ~~13.59H~~ **any other procedure at the same encounter by the same or different physician.**

52.31A Limited neck dissection (suprahyoid)
NOTE: HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician.

52.31B Modified neck dissection with preservation of either one or two of the non-lymphatic structures, (e.g., sternocleidomastoid muscle, jugular vein or spinal accessory nerve), unilateral including removal of all neck lymph nodes
NOTE**: 1.** May not be claimed with **HSCs** 17.08G, 50.72C, 95.14E.
2. HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician.

52.31C Functional or selective neck dissection with preservation of all non-lymphatic structures, (e.g., sternocleidomastoid muscle, jugular vein, spinal accessory nerve), unilateral, including removal of three or more nodal levels in the neck
NOTE: **1.** May not be claimed with **HSCs** 17.08G, 50.72C, 95.14E.
2. HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician.

52.31D Extended neck dissection
Removal of all neck lymph nodes and some non-lymphatic structures other than spinal accessory nerve, sternocleidomastoid muscle, or jugular vein. These structures may include the scalene muscle, deep neck muscles, hypoglossal nerve, carotid artery extensive resection of skin, etc, all related to or required because of tumor invasion of those structures
NOTE: **1.** May not be claimed with **HSCs** 17.08G, 50.72A, 50.72C, 95.14C, 95.14E.
2. HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician.

SECTION OF PLASTIC SURGERY

17.33 Release of carpal tunnel
NOTE: May not be claimed in addition to HSC 17.39C.

98.51F Free flaps involving microsurgical technique and neuro-vascular hook-up, **for procedures not related to head and neck reconstruction**, full 60 minutes or major portion thereof for the first call when only one call is claimed
NOTE: 1. May not be claimed in addition to HSCs 52.31A, 52.31B, 52.31C or 52.31D by the same or different physician at the same encounter.
2. The total time claimed for HSC 98.51F may only reflect the time spent providing micro surgery and may not include time spent providing other services.

17.39B Major nerve exploration
NOTE: 1. May not be claimed for the release of carpal tunnel (HSC 17.33) or procedures/diagnostic conditions related to carpal tunnel.
2. May not be claimed in addition to HSC 17.39C.

17.39C Release ulnar nerve (includes transposition)
NOTE: May not be claimed with **HSCs** 17.5 A, **17.33 or 17.39B.**

52.31A Limited neck dissection (suprahyoid)
NOTE: HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician.

52.31B Modified neck dissection with preservation of either one or two of the non-lymphatic structures, (e.g., sternocleidomastoid muscle, jugular vein or spinal accessory nerve), unilateral including removal of all neck lymph nodes
NOTE**: 1.** May not be claimed with **HSCs** 17.08G, 50.72C, 95.14E.
2. HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician.

52.31C Functional or selective neck dissection with preservation of all non-lymphatic structures, (e.g., sternocleidomastoid muscle, jugular vein, spinal accessory nerve), unilateral, including removal of three or more nodal levels in the neck
NOTE: **1.** May not be claimed with **HSCs** 17.08G, 50.72C, 95.14E.
2. HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician.

52.31D Extended neck dissection
Removal of all neck lymph nodes and some non-lymphatic structures other than spinal accessory nerve, sternocleidomastoid muscle, or jugular vein. These structures may include the scalene muscle, deep neck muscles, hypoglossal nerve, carotid artery extensive resection of skin, etc, all related to or required because of tumor invasion of those structures
NOTE: **1.** May not be claimed with **HSCs** 17.08G, 50.72A, 50.72C, 95.14C, 95.14E.
2. HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician.

SECTION OF PSYCHIATRY

08.11A Requiring complete mental status examination and investigation, first full 45 minutes or major portion thereof for the first call when only one call is claimed
NOTE: 1. May only be claimed for the initial visit.
2. When visit does not require complete examination and investigation, the appropriate office visit HSC should be claimed.
3. HSCs 08.19GA or 08.19GB may not be claimed at the same encounter. The total time spent providing the non-referred first visit must be claimed using the applicable non-referred first visit code.

08.11C For complex patient, requiring complete mental status examination and investigation, first full 45 minutes or major portion thereof for the first call when only one call is claimed
NOTE: 1. May only be claimed for the initial visit.
2. May only be claimed by psychiatrists.
3. May only be claimed when the patient meets the criteria outlined in note 4 and the score is identified in the patient's chart at least once every six months.
4. Complex patient is defined as:
a. An adult with a Global Assessment of Function (GAF) score of 40 or less.
b. A child with a Children's Global Assessment of Function (CGAS) score of 41 or less.
5. HSCs 08.19GA or 08.19GB may not be claimed at the same encounter. The total time spent providing the non-referred first visit must be claimed using the applicable non-referred first visit code.

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

08.19AA Formal major psychiatric consultation for a patient referred by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist, first full 30 minutes or major portion thereof for the first call when only one call is claimed
NOTE: 1. May be claimed when a patient is referred to a psychiatrist by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist and the provisions that apply to consultations under GRs 4.3, 4.4 and 4.6 are met.
2. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 30 minutes has elapsed.
3. HSCs 08.19GA or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.

08.19B Minor psychiatric consultation, full 15 minutes or major portion thereof for the first call when only one call is claimed.
NOTE: HSCs 08.19GA or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.

08.19BB Minor psychiatric consultation for a patient referred by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist, full 15 minutes or major portion thereof for the first call when only one call is claimed
NOTE: **1**. May be claimed when a patient is referred to a psychiatrist by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist and the provisions that apply to consultations under GRs 4.3, 4.4 and 4.6 are met.
2. HSCs 08.19GA or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.

08.19C Repeat psychiatric consultation, per full 30 minutes or major portion thereof for the first call when only one call is claimed
NOTE: HSCs 08.19GA or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.

08.19CC Repeat psychiatric consultation for a patient referred by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist, per full 30 minutes or major portion thereof for the first call when only one call is claimed
NOTE: **1.** May be claimed when a patient is referred to a psychiatrist by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist and the provisions that apply to consultations under GRs 4.3, 4.4 and 4.6 are met.
2. HSCs 08.19GA or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.

08.19GA Direct contact with a patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or psychiatric counseling, per 15 minutes or major portion thereof

NOTE: 1. May only be claimed by a psychiatrist (PSYC), a generalist in Mental Health (GNMH) or by a specialist in Mental Health (SPMH) if the intent of the session is the therapy of one individual patient, whether or not more than one person is involved in the session.
2. May be claimed for both referred and non-referred patients with psychiatric disorders.
3. May not be claimed at the same encounter as HSCs 08.11A, 08.11C, 08.19A, 08.19AA, 08.19B, 08.19BB, 08.19C or 08.19CC.

08.19GB Direct contact with a complex patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or psychiatric counseling, per 15 minutes or major portion thereof
NOTE: 1. May only be claimed by a psychiatrist or a generalist in mental health.
2. May only be claimed when the patient meets the criteria outlined in note 3 and the score is identified in the patient's chart at least once every six months.
3. Complex patient is defined as:
a. An adult with a Global Assessment of Function (GAF) score of 40 or less.
b. A child with a Children's Global Assessment of Function (CGAS) score of 41 or less.
4. May not be claimed at the same encounter as HSCs 08.11A, 08.11C, 08.19A, 08.19AA, 08.19B, 08.19BB, 08.19C or 08.19CC.