Alberta Government

Bulletin

Alberta Health Care Insurance Plan

Number: Med 182	**Date:** April 1, 2016	**Page:** 1 of 1
Subject: Schedule of Medical Benefits amendments April 1, 2016	**Reference:** Schedule of Medical Benefits	

To: all physicians and billing staff

Amendments have been made to the Schedule of Medical Benefits effective April 1, 2016. Please refer to the Bulletin Attachments A to C for details. New text is shown in bold print and amended text is shown in bold print and underlined in the attachments.

- Attachment A contains amended General Rules
- Attachment B contains amended, new and deleted Health Service Codes
- Attachment C contains amended Modifiers

The April 1, 2016 Schedule is available on line at www.health.alberta.ca/professionals/fees.html

The Alberta Medical Association website at www.albertadoctors.org also contains a link to the schedule.

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Attachment A
Amended General Rules

Amended General Rules

- These GRs have had HSCs added and/or deleted accordingly:

GR 4.4.8 GR 6.5 GR 6.8.4 e) GR 6.9.7 g) GR 13.3

- GR 12.7 has been amended to update the rate.

Attachment B

Amended, new and deleted Health Service Codes

Amended Health Service Codes

03.01LG	03.01LH	03.01LI	03.01LJ	03.01LK	03.01LL	03.01LT
03.01NG	03.01NH	03.01NI	03.01O	03.03F	03.03FA	03.03Q
03.04K	03.05B	03.05JP	03.08I	08.11B	08.19G	08.19GA
09.43	10.04B	13.99BC	14.49H	14.49J	15.12A	19.7 B
20.73	29.0 B	43.0 B	46.91	48.98A	48.98B	49.95A
50.4 F	50.93A	50.94D	51.59A	51.59B	51.59D	51.59E
51.59F	55.3	56.2	57.42A	57.59A	58.73	58.75A
62.12C	63.12A	63.12B	63.14	63.27	63.69A	64.3
64.43A	64.7	66.51A	66.83	66.91A	97.27B	98.12Q
X 26	X 26A	X 26B	X 26C	X 27	X 27E	X 27F
X 88A	X105A					

■ **03.01LG –** Amend to read as follows:
Physician to physician or podiatric surgeon telephone or telehealth **videoconference or secure** videoconference consultation, referring physician, weekdays 0700 to 1700 hours
NOTE: Refer to notes following HSC 03.01LI.

■ **03.01LH** – Amend to read as follows:
Physician to physician or podiatric surgeon telephone or telehealth **videoconference or secure** videoconference consultation, referring physician, weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours
NOTE: Refer to notes following HSC 03.01LI.

■ **03.01LI** – Amend description and add Note 7 to read as follows:
Physician to physician or podiatric surgeon telephone or telehealth **videoconference or secure** videoconference consultation, referring physician, any day 2200 to 0700 hours
NOTE: 7. 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.

Amended Health Service Codes (con't)

■ **03.01LJ** – Amend to read as follows:
Physician or podiatric surgeon to physician telephone or telehealth **videoconference or secure v**ideoconference consultation, consultant, weekdays 0700 to 1700 hours
NOTE: Refer to notes following HSC 03.01LL.

■ **03.01LK –** Amend to read as follows:
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** – Amend description and add Note 7 to read as follows:
Physician or podiatric surgeon to physician telephone or telehealth **videoconference or secure** videoconference consultation, consultant, any day 2200 to 0700 hours
NOTE: 7. 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.

■ **03.01LT** – Amend description and note to read as follows:
Online medical control (OLMC) - Telephone calls from EMS practitioners on site to OLMC physicians on duty **weekdays 0700-1700 hours**
NOTE: **Refer to the notes following HSC 03.01LV**

HSC 03.01LT was amended and new HSCs 03.01LU and 03.01LV are introduced to have payment made based on the time of day the service was provided. See the New Health Service Codes section of this Bulletin for details.

■ **03.01NG** – Amend to read as follows:
Patient care advice to paramedic - pre hospital patch, assisted living/designated assisted living and lodge staff, active treatment facility worker for hospital in-patient, long term care worker for patients in a long term care facility, nurse practitioner**, hospice worker,** home care worker, **or public health nurse** weekdays 0700 to 1700 hours, provided via telephone or other telecommunication methods, in relation to the care and treatment of a patient
NOTE: Refer to notes following HSC 03.01NI.

■ **03.01NH -** Amend to read as follows:
Patient care advice to paramedic - pre hospital patch, assisted living/designated assisted living and lodge staff, active treatment facility worker for hospital in-patient, long term care worker for patients in a long term care facility, nurse practitioner**, hospice worker,** home care worker, **or public health nurse** weekdays 1700 to 2200 hours, weekends and statutory holidays, 0700 to 2200 hours, provided via telephone or other telecommunication methods, in relation to the care and treatment of a patient
NOTE: Refer to notes following HSC 03.01NI.

Amended Health Service Codes (con't)

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

NOTE: 1. Active treatment facility worker may include registered: nurse, licensed practical nurse, occupational therapist, physiotherapist, speech language pathologist, social worker, pharmacist, psychologist, recreational therapist or respiratory therapist.

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

■ **03.01O** – Amend description and Note 1 to read as follows:
Physician to Physician **secure** E-Consultation, consultant
NOTE: 1. May only be claimed when both the **referring and consulting physician exchange communication using a secure email 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 acceptable to the Office of the Privacy Commissioner of Alberta**.

"Secure email" refers to any secure electronic communication.

Amended Health Service Codes (con't)

■ **03.03F** - Amend Price List to remove DERM skill modifier code.

■ **03.03FA** – Add GAST and RSMD modifier codes to Price List and amend description to read as follows:
Prolonged repeat office or scheduled outpatient visit in a regional facility, referred cases only, full 15 minute or portion thereof for the first call when only one call is claimed
NOTE: 1. May only be claimed in addition to HSC 03.03F when the 03.03F exceeds 30 minutes.
2. May only be claimed by pediatrics (including subspecialties) and clinical immunology and allergy for patients 18 years of age and under, or by cardiology, endocrinology/metabolism, **gastroenterology,** infectious diseases, internal medicine, hematology, medical genetics, physiatry, **respiratory medicine,** rheumatology, urology and vascular surgery (no age restriction).

■ **03.03Q** – Add the following modifiers to the Price List:
SUBD OFEV Y Increase Base By
SUBD OFEVWK Y Increase Base By
SUBD OFNTAM Y Increase Base By
SUBD OFNTPM Y Increase Base By

■ **03.04K** – Amend Note 2 to read as follows:
NOTE: 2. May only be claimed in a**n AHS** regional facility **or AHS/Contracted partner run geriatric program(s) or community clinic where a PCN multi-disciplinary team is contributing to the assessment**.

■ **03.05B** – Change the maximum number of calls listed in the Price List from 14 to 6 and amend notes to read as follows:
Trauma care visit
NOTE: 1. Trauma care visit includes daily visit, review of blood work, laboratory and x-ray results, and management of care with co-ordination of required consultations. The first day of trauma care may be claimed using HSC 13.99GA.
2. May only be claimed by the co-ordinating surgical specialist.
3. May not be claimed in addition to a major surgical procedure performed by the same (trauma) physician.
4. May only be claimed for referred cases.
5. **A maximum of 6 HSC 03.05B (one for each hospital day) may be claimed for care delivered following the trauma admission (HSC 13.99GA).**
6. Daily hospital visits for those trauma patients requiring care past seven days, should be claimed using HSC 03.03D beginning on the eighth day and onwards.
7. May be claimed in addition to care provided by intensivists.

■ **03.05JP –** Amend to read as follows:
Family conference via telephone relating to acute care facility in-patient or registered emergency or out-patient, or auxiliary hospital, nursing home patient, **hospice patient,** AACC or UCC patient

■ **03.08I** – Add RSMD skill modifier code to Price List and amend description to read as follows:
Prolonged endocrinology/ metabolism, gastroenterology, hematology, infectious diseases, internal medicine, nephrology, physiatry, neurology**, respiratory medicine** or rheumatology consultation or visit, full 15 minutes or major portion thereof for the first call when only one call is claimed

Amended Health Service Codes (con't)

■ **08.11B** - Delete skill modifier codes GNMH and PSYC from the Price List and amend notes to read as follows:
Evidence from a psychiatrist at a Review Panel on behalf of a specific patient, as required under section 37(3) of the Mental Health Act, per 15 minutes or portion thereof
NOTE: **1.** This service is to be claimed using the Personal Health Number of the patient.
2. May only be claimed by a psychiatrist or a generalist in mental health.

■ **08.19G –** Amend Price List to remove skill modifier codes GNMH and SESU.

■ **08.19GA** – Add skill modifier code GNMH to Price List and amend note 1 as follows:
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.

■ **10.04B –** Amend to add BMIPRO modifier to Price List.

■ **13.99BC –** Amend to add note to read as follows:
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.

■ **14.49H –** Amend Price List to update the maximum rates for 2MSU and 2MNU modifiers

■ **14.49J -** Amend Price List to update the maximum rates for 2MSU and 2MNU modifiers

■ **15.12A -** Amend Price List to update the maximum rates for 2MSU and 2MNU modifiers

■ **19.7 B –** Amend to add note to read as follows:
Parathyroidectomy with mediastinal exploration
NOTE: May not be claimed in addition to HSC 20.73.

■ **20.73 –** Amend to add note to read as follows:
Total excision of thymus
NOTE: May not be claimed in addition to HSC 19.7 B.

■ **29.0 B –** Change the maximum number of calls listed in the Price List from 3 to 4 and amend note to read as follows:
Orbitotomy for decompression
NOTE: A second**,** third **or fourth** call may be claimed at the rate specified on the Price List.

Amended Health Service Codes (con't)

■ **43.0 B –** Amend description and notes to read as follows (incorporate note 1 into the description):
Injection of Botulinum A Toxin**, for spastic dysphonia**
NOTE: HSC 01.03 may be claimed in addition.

■ **46.91 –** Amend to add BMIPRO modifier to Price List.

■ **48.98A –** Amend to add note.
Selective angiography of aortocoronary vein bypass graft, per graft
NOTE: May not be claimed in addition to HSCs 50.91D or 50.91E.

■ **48.98B –** Amend note to read as follows:
Coronary angiography
NOTE: May not be claimed in addition to HSC**s 50.91D or 50.91E**.

■ **49.95A –** Amend Price List to remove modifier LVP50 and add modifier ADD.

■ **50.4 F –** Amend to remove note.

■ **50.93A –** Amend to add BMIPRO modifier to Price List.

■ **50.94D –** Amend to add BMIPRO modifier to Price List.

■ **51.59A –** Amend to add note to read as follows:
Open transluminal angioplasty
NOTE: 1. Benefit includes intra-operative angiography.
2. Benefit will be reduced when performed in association with another vascular procedure; refer to Price List.
3. May not be claimed in addition to HSCs 50.91D or 50.91E.

■ **51.59B –** Amend to add note to read as follows:
Percutaneous transluminal angioplasty, excluding coronary vessels
NOTE: May not be claimed in addition to HSCs 50.91D or 50.91E.

■ **51.59D -** Amend to add note to read as follows:
Percutaneous transluminal coronary angioplasty with associated diagnostic angiogram
NOTE: 1. May be claimed when the diagnostic angiogram is intended to determine appropriate treatment of the patient's coronary anatomy and is immediately followed by a coronary angioplasty by the same cardiologist.
2. Benefit includes other angiograms performed on the same date of service.
3. For each additional coronary vessel, refer to Price List.
4. Role modifier ASIC may be claimed for assistance at coronary angioplasty by a second interventional cardiologist.
5. May not be claimed in addition to HSCs 50.91D or 50.91E.

Amended Health Service Codes (con't)

■ **51.59E -** Amend to add note to read as follows:
Percutaneous transluminal coronary angioplasty without associated angiogram
NOTE: 1. Patient will have had a previous angiogram to determine appropriate treatment.
2. May be claimed where the diagnosis has been determined and the patient's need for angioplasty has been established before the date of the procedure.
3. Coronary angiography may not be claimed on the same date of service by the same or different physician.
4. For each additional coronary vessel, refer to Price List.
5. Role modifier ASIC may be claimed for assistance at coronary angioplasty by a second interventional cardiologist.
6. May not be claimed in addition to HSCs 50.91D or 50.91E.

■ **51.59F -** Amend to add note to read as follows:
Percutaneous transluminal coronary angioplasty without associated angiogram
NOTE: 1. May be claimed when another physician has performed the angiogram on the same date of service which established the need for the angioplasty and has claimed 48.98B for the coronary angiogram.
2. Coronary angiography (48.98B) may not be claimed by the same physician on the same date of service.
3. For each additional coronary vessel, refer to Price List.
4. Role modifier ASIC may be claimed for assistance at coronary angiography by a second interventional cardiologist when medically required.
5. May not be claimed in addition to HSCs 50.91D or 50.91E.

■ **55.3 –** Amend Price List to remove modifier LVP75 and add modifier LVP50.

■ **56.2 –** Amend note to read as follows:
Gastroenterostomy (without gastrectomy)
NOTE: May not be claimed with HSCs 64.3, 64.43A, 64.49**A** or 64.7.

■ **57.42A –** Amend to add note to read as follows:
Small bowel resection
NOTE: 1. May only be claimed with HSC 57.59A when two anastomoses are performed.
2. May only be claimed with HSC 60.52B when two discontinuous areas are resected and two anastomoses are performed.
3. May not be claimed in addition to HSC 63.12B.

■ **57.59A –** Amend note to read as follows:
Partial or segmental colectomy
NOTE: 1. Benefit includes right hemicolectomy, left hemicolectomy, sigmoid colectomy or extended right hemicolectomy.
2. More than one call may be claimed if two or more anastomoses are performed.
3. May only be claimed with HSC 60.52B when two discontinuous areas are resected and two anastomoses are performed.
4.May not be claimed with HSC 60.52A **or 63.12B.**

Amended Health Service Codes (con't)

■ **58.73 –** Amend notes to read as follows:
Other suture of small intestine, except duodenum
NOTE: **1.** May not be claimed for incidental bowel perforations.
2. May not be claimed in addition to HSC 63.12B.

■ **58.75A –** Amend notes to read as follows:
Suture of large or small intestine
NOTE: **1.** May not be claimed for incidental bowel perforations.
2. May not be claimed in addition to HSC 63.12B.

■ **62.12C –** Amend description and notes to read as follows:
Partial resection **of liver**
NOTE: **1.** May not be claimed for wedge biopsy.
2. May not be claimed in addition to HSC 62.2B or 63.12B.

■ **63.12A –** Amend Price List to remove modifier LVP75 and add modifier LVP50 and amend description and add note to read as follows:
Open surgical cholecystectomy
NOTE: 1. May not be claimed for laparoscopic cholecystectomy.

■ **63.12B –** Amend to add note to read as follows:
Cholecystectomy with closure of fistula to duodenum or colon
NOTE: May not be claimed in addition to HSCs 57.42A, 57.59A, 58.73, 58.75A, 62.12C or 62.2 B.

■ **63.14 –** Amend to add note to read as follows:
Laparoscopic cholecystectomy
NOTE: May not be claimed for open surgical cholecystectomy.

■ **63.27 –** Amend note to read as follows:
Anastomosis of hepatic duct to gastrointestinal tract
NOTE: HSCs 63.22 and 63.27 may not be claimed in addition to HSCs **63.41, 63.69A,** 64.3, 64.43A, 64.49**A** or 64.7.

■ **63.69A –** Amend description and notes to read as follows:
Resection and reconstruction of common bile duct including secondary plastic repair **and all anastomoses**
NOTE: May not be claimed in addition to HSCs 52.2, 57.7, 62.12C or 62.2 B.

■ **64.3 –** Amend note to read as follows (remove reference to HSC 63.26):
Internal drainage of pancreatic cyst Pancreatico-cystoenterostomy
NOTE: May not be claimed with HSCs 56.2, 63.22, 63.27 and 64.7.

■ **64.43A –** Amend note to read as follows (remove reference to HSC 63.26):
Pancreatectomy 95% resection
NOTE: 1. May be claimed in addition to HSC 66.83.
2. May not be claimed with HSCs 56.2, 63.22, 63.27 and 64.7.

Amended Health Service Codes (con't)

■ **64.7 –** Amend note to read as follows (remove reference to HSC 63.26):
Anastomosis of pancreas (duct) Pancreatico-enterostomy
NOTE: May not be claimed with HSCs 56.2, 63.22, 63.27, 64.3, 64.43A or 64.49**A**.

■ **66.51A –** Amend to read as follows:
Post-operative closure or delayed primary closure abdominal wall

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

■ **66.91A –** Amend to add BMIPRO modifier to Price List.

■ **97.27B – A**dd modifier LVP50 to Price List and amend description and add note to read as follows:
Segmental resection with sentinel node biopsy
NOTE: When claimed in addition to HSC 52.42, the benefit will be paid at LVP50.

■ **98.12Q –** Amend to read as follows:
Removal of **any atypical or neoplastic lesion(s) – any method excluding cryotherapy for actinic keratosis**
Example: Multiple dysplastic naevi syndrome**, multiple basal and/or squamous cell carcinomas**
NOTE: A maximum of five calls may be claimed.

■ **X 26 –** Amend to add note to read as follows:
Mammography (one breast)
NOTE: May not be claimed in addition to HSC X105A.

■ **X 26A –** Amend to add note to read as follows:
Mammoductography
NOTE: May not be claimed in addition to HSC X105A.

■ **X 26B –** Amend to add note to read as follows:
Mammocystography
NOTE: May not be claimed in addition to HSC X105A.

■ **X 26C –** Amend to add note to read as follows:
Percutaneous stereotactic core breast biopsy imaging guidance
NOTE: May not be claimed in addition to HSC X105A.

■ **X 27 –** Amend to add note to read as follows:
Mammography (both breasts)
NOTE: May not be claimed in addition to HSC X105A.

Amended Health Service Codes (con't)

■ **X 27E –** Amend to add note to read as follows:
Screening mammography (age 75 years 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. **7.** X27C**, X27D or X27E may not be claimed in addition to HSC X105A.**

■ **X 27F –** Amend note to read as follows:
Diagnostic mammography, supplementary views
Taken within 90 days of X27C, X27D, X27E
NOTE: 1. May be self-referred.
2. May not be claimed in addition to **HSCs** X26**,** X27 **or X105A**.

■ **X 88A –** Amend note to read as follows:
Barium enema for the reduction of intussusception
NOTE: If any of the above procedures (HSCs X81 through X88A) are performed without fluoroscopy the benefit should be reduced by $**10.92**.

■ **X105A –** Amend to add note to read as follows:
Multi-directional tomography, any area
NOTE: May not be claimed in addition to HSCs X 26, X 26A, X 26B, X 26C, X 27, X 27C, X 27D, X 27E, X 27F or X 27G.

New Health Service Codes:

This attachment contains Procedure List details only. Full Procedure List and Price List details have been provided to accredited submitters and are contained in the April 1, 2016 Schedule of Medical Benefits posted online (see Page 1 for the link).

■ 03.01LU Online medical control (OLMC) - Telephone calls from EMS practitioners on site to OLMC physicians on duty weekdays 1700 - 2200 hours, weekends and statutory holidays 0700 – 2200 hours
NOTE: Refer to the notes following HSC 03.01LV.

■ 03.01LV Online medical control (OLMC) - Telephone calls from EMS practitioners on site to OLMC physicians on duty any day 2200 – 0700 hours

NOTE: 1. May only be claimed in those situations where the call to the OLMC physician has been dispatched through the STARS Link Centre, or a similar central dispatch centre for calls of this nature, on behalf of an EMS practitioner in attendance at an emergency situation where the EMS protocols, or the judgement of the EMS practitioner, necessitate contact with the OLMC physician.

2. **May only be claimed when the OLMC physician has provided an opinion and recommendations for patient management to the EMS practitioner after reviewing the patient's history and condition with the EMS practitioner as well as review of laboratory and other data where indicated.**
3. **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.**
4. **A maximum of two claims may be claimed per patient, per physician, per day.**
5. **Documentation of the phone call must be recorded in their respective records.**

HSCs 03.01LU and 03.01LV are introduced to have payment made based on the time of day the service was provided. See HSC 03.01LT for the weekday 0700-1700 hours portion.

■ 03.01R Physician to Physician secure E-Consultation, referring physician

NOTE: 1. Time spent completing the referral may not be claimed using complexity modifiers.

2. **May only be claimed when both the referring and consulting physician exchange communication using a secure email 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 acceptable to the Office of the Privacy Commissioner of Alberta.**
3. **May not be claimed for situations where the purpose of the communication is to:**
4. **arrange for laboratory or diagnostic investigations**
   a) **discuss or inform of results of diagnostic investigations, or**
   b) **arrange for an expedited consultation with the patient**
5. **Documentation of the request and advice given must be recorded in the patient record.**
6. **This service may not be claimed for transfer of care alone.**

New Health Service Codes (cont'd):

■ 03.01S Physician to patient secure email communication

NOTE: 1. May only be claimed for medically necessary advice or follow up where the nature of the condition can safely be managed via secure email.

2. May only be claimed when the service is provided using a secure email 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 acceptable to the Office of the Privacy Commissioner of Alberta.

3. May only be claimed for those patients where an established physician-patient relationship exists and the physician has seen the patient in the previous 12 months.

4. Physicians and patients must have previously discussed and agreed to the limitations of health management using electronic means.

5. The secure email/messaging system must inform patients when the physician is unavailable.

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

7. A maximum of seven 03.01S per calendar week per physician may be claimed.

8. A visit service may not be claimed if provided within 24 hours following the electronic communication.

9. Only one 03.05JR, 03.01S, or 03.01T may be claimed per patient per physician per week.

10. May not be claimed when the service is provided by a physician proxy.

11. Documentation of the service must be recorded in the patients' record.

12. May not be claimed for inpatients.

■ 03.01T Physician to patient secure videoconference

NOTE: 1. May only be claimed for medically necessary advice or follow up where the nature of the condition can safely be managed via secure videoconference.

2. May only be claimed for those patients where an established physician-patient relationship exists and the physician has seen the patient in the previous 12 months.

3. 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 acceptable to the Office of the Privacy Commissioner of Alberta.

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

5. A maximum of seven 03.01T per calendar week per physician may be claimed.

6. A visit service may not be claimed if provided within 24 hours following the electronic communication.

7. Only one 03.05JR, 03.01S, or 03.01T may be claimed per patient per physician per week.

8. May not be claimed when the service is provided by a physician proxy.

9. Documentation of the service must be recorded in the patients' record.

10. May not be claimed for inpatients.

New Health Service Codes (cont'd):

■ 03.03NA Home visit to patients residing in Assisted Living, Designated Assisted Living (DAL), group homes, seniors lodges or personal care home, first patient

NOTE: 1. A maximum of one visit per day, per facility may be claimed. For the subsequent patient seen in the same facility on the same date of service, see HSC 03.03NB.

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

3. Modifiers OFEV, OFEVWK, OFNTAM or OFNTPM may only be claimed if a special call for attendance is received and the physician attends within 24 hours of receiving the call.

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

■ 03.03NB Home visit to patients residing in Assisted Living, Designated Assisted Living (DAL), group homes, seniors lodges or personal care home, second/subsequent patients

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

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

3. Modifiers OFEV, OFEVWK, OFNTAM or OFNTPM may only be claimed if a special call for attendance is received and the physician attends within 24 hours of receiving the call.

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

HSCs 03.03NA and 03.03NB should be used for those patients that do not reside in AHS long term care or their own home that is a single family residence. These codes are to be billed where there are multiple patients residing in Assisted living, Designated Assisted Living (DAL), group homes, seniors lodges or personal care homes. HSCs 03.03N and 03.03P should no longer be billed for home visits for these patients.

■ 03.05JH Family conference via telephone, in regards to a community patient

NOTE: 1. This service is to be claimed using the Personal Health Number of the patient.

2. May be claimed in situations where:

a) location or mobility factors of family members at the time of the call preclude in person meetings.

b) communication about a patient's condition or to gather collateral information that is relative to patient management and care activities.

3. May not be claimed for:

a) relaying results for lab or diagnostics.

b) arranging follow up care.

4. Documentation of the communication to be maintained in the patient record.

5. May be claimed in the pre and post-operative periods.

■ 03.11 Vision screening examination

03.11A Visual assessment for patients presenting with acute visual disturbances or painful eye(s)

NOTE: 1. Assessment must include anterior and posterior chamber examinations, examination of retina, and may include pressure assessment if necessary.

2. May not be claimed for conditions or procedures related to obvious conjunctivitis, allergic conjunctival conditions, stye, eye lid conditions, foreign body or other similar conditions.

New Health Service Codes (cont'd):

■ 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 a visit or consultation.
3. May not be claimed at the same encounter as HSC 13.99BC.

■ 25.69 Other repair of cornea

25.69A Therapeutic corneal cross-linking examination for progressing cases of keratoconus or pellucid marginal degeneration, per eye

NOTE: 1. May not be claimed for services provided in association or in relation to refractive surgery either 2 years preceding refractive surgery or 2 years following refractive surgery. Patient must have a greater than 1 dioptre change in refractive astigmatism and a greater than one line loss of corrected acuity documented over a minimum of three examinations (one baseline and two follow ups).
2. May only be claimed for epithelium-off procedures.

Corneal cross linking was previously billed as a by-assessment item (HSC 99.09C). Claims for services provided April 1, 2016 and onward must be submitted using HSC 25.69A not HSC 99.09C.

■ 50.91D Radial arterial line access

NOTE: May not be claimed in addition to HSCs 48.98A, 48.98B, 51.59A, 51.59B, 51.59D, 51.59E and 51.59F.

■ 50.91E Femoral arterial line access

NOTE: May not be claimed in addition to HSCs 48.98A, 48.98B, 51.59A, 51.59B, 51.59D, 51.59E and 51.59F.

■ 62.2 B Lobectomy of liver - 4 or more hepatic segments

NOTE: May not be claimed in addition to HSC 62.12C or 63.12B.

■ 63.99D Biliary drain exchange

Biliary drain exchange was previously billed as a by-assessment item (HSC 99.09J). Claims for services provided April 1, 2016 and onward must be submitted using HSC 63.99D not HSC 99.09J.

■ 64.49 Other partial pancreatectomy

64.49A Other partial pancreatectomy – with or without splenectomy

NOTE: 1. May be claimed in addition to HSC 66.83.
2. May not be claimed with HSCs 56.2, 63.22, 63.27 and 64.7.

New Health Service Codes (cont'd):

■ **66.19E Intraperitoneal Chemotherapy**

Intraperitoneal chemotherapy was previously billed as a by-assessment item (HSC 99.09J). Claims for services provided April 1, 2016 and onward must be submitted using HSC 66.19E not HSC 99.09J.

■ **66.82 Biopsy of peritoneum**
66.82A Retroperitoneal mass biopsy

Retroperitoneal mass biopsy was previously billed as a by-assessment item (HSC 99.09U). Claims for services provided April 1, 2016 and onward must be submitted using HSC 66.82A not HSC 99.09U.

■ **76.39 Other repair of penis**
76.39A Repair of penile fracture

■ **95.94C Ultrasound guidance during injection of soft tissue (trigger point), peripheral nerve, muscle, tendon, ligament, bursa or joint, additional benefit**
NOTE: 1. May only be claimed by Physical Medicine and Rehabilitation.
2. May only be claimed with HSCs 13.59H, 13.59J, 16.89B, 16.89D, 16.99A, 17.71A, 92.78C, 93.91A, 93.91B, 95.93 and 95.96A.

HSCs 95.94C may not be claimed when using hand held ultrasound machines. May only be claimed by Physical Medicine and Rehabilitation specialists that have completed training in the area of joint injections or American Registry for Diagnostic Medical Sonography (ARDMS) qualified physicians.

■ **X 27G Screening mammography for patients with the following conditions: implants, augmentation, mammoplasty, and when determined appropriate for screening by a radiologist and/or primary care physician, with the following conditions: post intervention (e.g. biopsy, excision, etc.)**
NOTE: May not be claimed in addition to HSC X105A.

Deleted Health Service Codes (and their replacement if applicable):

50.91A – see HSCs 50.91D and 50.91E

62.2 – see HSC 62.2 B

63.26 – see HSC 63.69A

63.95A

64.49 – see HSC 64.49A

95.35A

98.6 Q

X 49

Attachment C

Amended Modifiers

■ **Modifier CMXC30:** (remove reference to HSC 03.08G)

CMXC30 CMXC30 COMPLEX PATIENT CONSULTATION/VISIT - (Explicit) – This modifier is used to indicate a complex patient consultation or visit requiring that the physician spend 30 minutes or more on management of the patient's care.
1. May only be claimed for HSCs 03.04A, 03.04B, 03.04C, 03.04D, 03.04E, 03.04F, 03.04FA, 03.04G, 03.04GA, 03.04H, 03.04HA, 03.04M, 03.08A, 03.08B, 03.08C, 03.08F, 03.08H, 03.08K and 03.09A.
2. May be claimed with HSC 03.08A when claiming prolonged consultations, ie. HSCs 03.08I, 03.08J, 03.08L, 03.08M.

■ **Modifier SUBD:**

SUBD SUBD SUBDIVISION - (Explicit) - This modifier type is used with visit health service codes to indicate during which time period the service recipient/service provider encounter took place. These modifiers are applicable during the evening on weekdays, during the day and evening on weekends and statutory holidays, and during the night on any day. A fee is added to the base rate as indicated by the modifier.
For home visits **and hospice visits**, the SUBD modifier should be claimed based on the time at which the encounter commences and the physician responds on an unscheduled basis within a 24 hour period from the time of the call.