Billing Corner

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March 2009

Alberta Health Care Insurance Plan
Schedule of Medical Benefits
Changes for April 1, 2009

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Disclaimer: While care has been taken to communicate accurate information about Schedule of Medical Benefits (SOMB) changes for April 1, the Alberta Medical Association (AMA) does not guarantee accuracy of the information provided. Please refer to the SOMB for complete details. If you deliver services that are specific to more than one area of practice, the AMA recommends you review information provided for each section, as applicable.

AFTER-HOURS PAYMENTS CHANGES FOR ALL PHYSICIANS

Do you work in the evening and/or weekends in active treatment hospitals, nursing homes or auxiliary hospitals, Advanced Ambulatory Care Centres (AACCs) or Urgent Care Centers (UCCs)? You will need to review this important information about how to appropriately claim for services provided between the hours of 1700 – 0700 weekdays and anytime on the weekends or statutory holidays.

Highlights of the changes:

- Callback codes (to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home) have been renumbered and the benefit rates have been reduced.
- Callbacks can be claimed in addition to visits ONLY.
- Surcharge dollars have been reduced.
- Rotation duty surcharges have been eliminated.
- Rates for HSC 03.01AA time units have been substantially increased.

Deleted callback codes and the new callback codes

Callbacks codes to the emergency department or long term care have been renumbered and the former callback codes have been deleted. The benefit rate has been reduced **BUT** you may claim a visit code in addition to the callback. The new callback codes and associated visits are as follows. Please note 03.03EA may be claimed in addition:

03.03K *Delete* health service code 03.03K and replace with 03.03KA.

03.03KA *Add* a new health service code 03.03KA:
Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, weekday, (0700-1700 hours).....$64.58

03.03L *Delete* health service code 03.03L and replace with 03.03LA.

03.03LA *Add* a new health service code 03.03LA:
Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, weekday, (1700-2200 hours) or on Saturday, or statutory holiday (0700-2200 hours).....$85.08

03.03MA *Delete* health service code 03.03MA and replace with 03.03MC.

03.03MC *Add* a new health service code 03.03MC:
Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, any day (2200-2400 hours).....$181.43

03.03MB *Delete* health service code 03.03MB and replace with 03.03MD:

03.03MD *Add* a new health service code 03.03MD:
Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, any day (2400-0700 hours) $181.43

03.03EA *Add* a new health service code 03.03EA:
Visit to long term care patient in association with a special callback (HSC 03.03KA, 03.03LA, 03.03MC, 03.03MD).....$25.89
PHMD $98.77

For emergency/outpatient departments, one of the following visits may be claimed in addition to a callback:

03.02A Abbreviated assessment
03.03A Visit not requiring complete history and evaluation
03.03B Prenatal visit
03.04A Comprehensive visit

For **long term care (LTC) or auxiliary hospital callbacks** please claim 03.03DF for intercurrent illness, or 03.03EA.

03.03DF *Add* a new health service code 03.03DF:
Visit to hospital in-patient in association with a callback (HSCs 03.05N, 03.05P, 03.05QA, 03.05QB, 03.05R) ..... [rate varies by specialty]
NOTE: May be claimed when HSC 03.03D has been claimed at a different encounter by the same or different physician.

The new rates for callbacks to **hospital in-patients** are as follows. **Please note, 03.03DF may be claimed in addition:**

03.05N Weekday (0700 - 1700 hours).....$ 64.58
03.05P Weekday, (1700 - 2200 hours) .....$ 85.08
03.05QA (2200-2400 hours) $181.43
03.05QB (2400-0700 hours) $181.43
03.05R Saturday, Sunday, or statutory holiday, (0700-2200 hours).....$ 85.08

Amendments to the Governing Rules regarding callbacks

Please check Governing Rule 15 to review all amendments that pertain to callbacks.

Some Examples:

Billing scenario 1:

On a Monday night at 2230 an internist gets a call from the nurse on the ward requesting that s/he come on a priority basis to the hospital to assess a patient's condition. The total time spent managing the patients' care is 38 minutes. The claim would look like this:

03.05QA	In-patient callback (2200 - 2400)	$ 85.08
03.03DF	Hospital visit in association with a callback	$ 51.25
03.01AA	(Modifier) TNTP03	$123.00
	Total	$259.33

Billing Scenario 2:

On a Saturday at 0200 a GP gets a call from the hospital to see a patient in the emergency department on a priority basis. Due to the nature of the illness/injury the physician takes a full history and performs a complete physical appropriate to their specialty. The service lasts for 50 minutes. The claim would look like this:

03.03MD	Callback (2400 - 0700)	$181.43
03.04A	(Modifier) CMXC30	$112.07
03.01AA	(Modifier) TNTA04	$164.00
	Total	$457.50

Rotation-duty off-hours benefits

Rotation-duty off-hours benefits are eliminated effective April 1, 2009. The after-hours time premium (03.01AA) will increase from $7.18 per 15 minute unit to $20.50 per 15 minute unit (TEV and TWK) and from $10.76 to $41.00 per 15 minute unit (TNTP, TNTA, TST).

The rotation-duty modifiers that are eliminated are: RDEV, RDNTPM, RDNTAM, RDWK

Surcharges

The benefit rate for the surcharge modifiers EV, NTPM, NTAM and WK will be reduced. The rates for the after-hours time premium units (03.01AA)will increase from $7.18 per 15 minute unit to $20.50 per 15 minute unit (TEV and TWK) and from $10.36 to $41.00 per 15 minute unit (TNTP, TNTA, TST).

The April 1, 2009 rates for surcharges are as follows:

EV	(W/D 1700 – 2200)	$ 44.69
NTPM	(2200 – 2400)	$107.22
NTAM	(2400 – 0700)	$107.22
WK	(0700 – 2200 Weekend and Stats)	$ 44.69

After-hours time premium 03.01AA

The benefit rate for the after-hours time premium (HSC 03.01AA) will increase substantially effective April 1, 2009.

This HSC is claimed on a time basis and pays strictly for the time spent managing the patients' care in relation to an insured service. This code may only be claimed for services provided to patients in active treatment hospitals, nursing homes, or auxiliary hospitals. It includes such activities as charting, reviewing but not waiting for lab or DI results, consulting with other health providers on the service about the patient's care, writing a referral/consultant letter and any other activities that are included in managing the patients' care.

03.01AA is claimed in 15 minute units and a claim for 03.01AA must include a modifier that signals the time of day and the length of time it took to provide the service. In the event that a service covers more than one time period more than one modifier will apply.

Example:

If the service started at 2015 hours and took 45 minutes the claim for 03.01AA would look like this:

Health service code 03.01AA modifier TEV03. The "TEV" portion of the modifier signals that the service was provided in the evening and the "03" portion of the modifier signals that the service took approximately 45 minutes.

The benefit rates for 03.01AA are as follows:

TEV	(W/D 1700 - 2200)	$20.50/15 minutes
TNTP	(2200 - 2400)	$41.00/15 minutes
TNTA	(2400 – 0700)	$41.00/15 minutes
TWK	(W/E 0700 - 2200)	$20.50/15 minutes
TST	(0700 - 2200 stat holidays)	$41.00/15 minutes

OTHER CHANGES APPLICABLE TO ALL PHYSICIANS

General Rules

GR 1.7 *Amend* GR 1.7 to read:
"family" means children**, grandchildren,** siblings, parents, **grandparents,** spouse **or** adult interdependent partner **or any person who is dependent on the practitioner for support in accordance with the Alberta Health Care Insurance Regulation.**

GR 2.3.1 *Add* GR 2.3.1:
Unless otherwise specified, services that may be claimed once per year may be claimed 365 days after the previous service date.

GR 3.1 *Amend* GRs 3.1a), b), c) and d*)* to read:
The following includes examples of, but is not limited to, services which are not a benefit under the Schedule and may not be claimed:

a) Advice by telephone or other telecommunication methods except as specified under specific **HSCs** or for telehealth services;
b) Ambulance services, except ambulance detention time HSC**s** 13.99K, **13.99KA, 13.99KB;**
c) **Anesthetic** materials;
d) Any service a physician provides to **his/her children, grandchildren, siblings, parents, grandparents, spouse or adult interdependent partner or any person who is dependent on the practitioner for support in accordance with the Alberta Health Care Insurance Regulation;**

GRs 4.3.1 and 4.3.2
Add "**physical therapist**" to GRs 4.3.1 and 4.3.2.

GRs 4.4.1, 4.4.2 and 4.4.3
Add "**physical therapist**" to GRs 4.4.1, 4.4.2 and 4.4.3.

GRs 4.4.5 and 4.4.6
Add "**physical therapist**" to GRs 4.4.5 and 4.4.6.

GR 4.4.8 *Add* 03.38X, 03.45A, 03.45B, 09.13E and 09.13F to GR 4.4.8.

Delete 09.13A.

GR 4.5.2 *Add* "**physical therapist**" to GR 4.5.2.

GR 4.6.1 *Add* 08.11C to GR 4.6.1.

GR 4.8.4 *Add* "**physical therapist**" to GR 4.8.4.

GR 6.8.4 *Add* 81.96 and 98.12G to GR 6.8.4e).
Delete 81.96A.

GR 6.9.7e) *Add* 52.12, 52.13, 52.42, 65.01C, 65.04B, 65.04C, 65.51, 65.9A, 65.9B, 91.36H, 91.88C, 93.96L, 97.11B, 97.22A, 97.29A to GR 6.9.7e).

Delete 91.36F and 93.87H.

GR 13.3 *Add* 03.38X, 03.45A, 03.45B, 21.31B, 49.7N, 96.01B, 96.02A, 96.02B to GR 13.3. *Delete* 23.99E.

GR 14.2 *Delete* 23.99E and 95.01A from GR 14.2.

GR 15.3 *Amend* GR 15.3 to read:
Benefits for UNSCHEDULED services (modifier SURC) and special callback **HSCs 03.03LA, 03.03MC, 03.03MD,** 03.05P, 03.05QA**,** 03.05QB **and 03.05R** are intended to cover a degree of disruption that a physician would have to experience to provide such services during:
- the evening on weekdays (1700 - 2200 hours),
- the day and evening on weekends and statutory holidays (0700 - 2200 hours)
- any night of the week (2200 - 0700 hours)

GR 15.5 *Amend* GR 15.5 to read:
Only one unscheduled service or special callback benefit may be claimed for each encounter with a patient. **In the event of a special callback, the following visit services may be claimed in addition: HSC 03.02A, 03.03A, 03.03B, 03.04A, 03.03DF or 03.03EA.**

GR 15.8 *Add* the following to GR 15.8:
c) HSCs 03.03DF and 03.03EA may be claimed in addition to a callback in accordance with GR 15.5.

GR 15.9.1 *Add* 13.99VA to GR 15.9.1j).

GR 15.10.6 *Delete* 23.99E from GR 15.10.6.

GR 15.11.1 *Amend* GR 15.11.1 to read:
A maximum of five (5) special callbacks, either **HSC 03.03KA**, 03.05N or any combination thereof may be claimed, per physician, in any given weekday day. The weekday day is defined as Monday - Friday (0700 - 1700 hours).

GR 15.11.2 *Amend* GR 15.11.2 to read:
A maximum of five (5) **HSC 03.03LA,** 03.05P or any combination thereof may be claimed, per physician, in any given weekday, Monday – Friday (1700 - 2200 hours).

GR 15.11.3 *Amend* GR 15.11.3 to read:
A maximum of fifteen (15) **HSC 03.03LA,** 03.05R or any combination thereof may be claimed, per physician, on any day of the weekend or statutory holiday, (0700 - 2200 hours).

GR 15.11.4 *Amend* GR 15.11.4 to read:
A maximum of two (2) **HSC 03.03MC,** 03.05QA or any combination thereof may be claimed, per physician, any day, (2200 - 2400 hours).

GR 15.11.5 *Amend* GR 15.11.5 to read:
A maximum of seven (7) **HSC 03.03MD**, 03.05QB or any combination thereof may be claimed, per physician, any day, (2400 - 0700 hours).

GR 17.5 *Add* "**physical therapist**" to GR 17.5.

Health Service Codes

03.03DF *Add* a new health service code 03.03DF:
Visit to hospital in-patient in association with a callback (HSC 03.05N, 03.05P, 03.05QA, 03.05QB, 03.05R) 30.75*
NOTE: May be claimed when HSC 03.03D has been claimed at a different encounter by the same or different physician.

Base rate. Rate varies by specialty.

03.03E *Amend* note 2 following health service code 03.03E to read:
2. **HSC 03.03EA and** special callbacks (HSCs 03.03AR, **03.03KA, 03.03LA, 03.03MC, 03.03MD**) may be claimed subsequent to a 03.03E in the same calendar week for the same patient by the same physician.

03.03EA *Add* a new health service code 03.03EA:
Visit to long term care patient in association with a special callback (HSC 03.03KA, 03.03LA, 03.03MC, 03.03MD).....25.89

03.03N *Add* a note to health service code 03.03N:
NOTE: May be claimed in addition to HSC 03.04J.

03.04A *Add* note **2** to health service code 03.04A:
2. May be claimed in addition to HSC 03.04J.

03.04M *Add* a new health service code 03.04M:
Pre-operative history and physical examination.....95.05

03.05JN *Add* a new health service code 03.05JN:
Second and subsequent physician attendance at a formal, scheduled, professional conference related to the care and treatment of multiple patients undergoing rehabilitation therapy including those with chronic pain, when discussion occurs on behalf of a specific patient.....17.18

NOTE:
1. HSC 03.05JM may only be claimed by Physiatry.
2. HSC 03.05JN may be claimed by any physician that is participating in the conference.
3. HSCs 03.05JM and 03.05JN are to be claimed using the Personal Health Number of the patient.
4. Each physician involved in a patient conference may claim for patient services using HSCs 03.05JM or 03.05JN, per patient, to a maximum of 6 patients in a 30 minute period.
5. HSC 03.05JN may be claimed when the physician most responsible for the patient's care has submitted a claim under 03.05JM.

03.05R *Amend* note 6 following health service code 03.05R to read:
6. May not be claimed in association with any HSC except **HSC** 03.01AA **or 03.03DF.** Refer to GR 15.8.

03.07A *Add* physical therapists to those allied health professionals with the ability to refer patients for minor consultations.

03.07B *Add* physical therapists to those allied health professionals with the ability to refer patients for repeat consultations.

03.08A *Add* physical therapists to those allied health professionals with the ability to refer patients for comprehensive consultations.

13.59A *Add* a note to health service code 13.59A:
NOTE: May be claimed in addition to a visit or a consultation.

13.99G *Amend* health service code 13.99G to read:
Trauma assessment, multiple trauma, severely injured patient**, first** day

NOTE:
1. Benefit includes the consultation and, when indicated, establishment of peripheral intravenous access, administration of oxygen, insertion of urinary catheter, spinal stabilization, oropharyngeal airway, and insertion of chest tube(s).
2. May be claimed only by the coordinating surgical specialist.
3. May not be claimed in addition to a major surgical procedure performed by the same (trauma) physician.
4. May be claimed for referred cases only.
5. Claims for **subsequent** day**s** of trauma care should be submitted using **HSC** 03.05B.
6. **Following the fourteenth day of trauma care, claims should be submitted for the appropriate level of hospital care.**
7. May be claimed in addition to care provided by intensivists.

16.81A *Add* note 2 to health service code 16.81A:
2. May be claimed in addition to a visit or consultation.

98.03A *Add* the following note to health service code 98.03A:
NOTE: May be claimed in addition to a visit or a consultation.

Modifiers

CMXC30 *Amend* note 1 following modifier CMXC30 to read:
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.

CMXV20 *Amend* the last paragraph of modifier CMXV20 to read:
This modifier may also be claimed by any physician for HSCs 03.05CR, 03.05DR, 03.05ER, 03.05F, **03.05FA, 03.05FB, 03.05FC, 03.05FD, 03.05FE, 03.05FF, 03.05FG,03.05FH, 03.05FR, 03.05GR, 03.05HR** when location and time conditions (above) are met.

CMXV35 *Amend* the last paragraph of modifier CMXV35 to read:
This modifier may also be claimed by any physician for HSCs 03.05CR, 03.05DR, 03.05ER, 03.05F, **03.05FA, 03.05FB, 03.05FC, 03.05FD, 03.05FE, 03.05FF, 03.05FG, 03.05FH, 03.05FR, 03.05GR, 03.05HR** when location and time conditions (above) are met.

REDO *Amend* the following REDO modifiers:
REDO REDO PROCEDURE - (Explicit) - Cardiac, Vascular, and Thoracic surgery as described in GR 6.15, re-operation for **specific ophthalmology procedures,** or **orthopedic** procedures as listed in GR 6.17.1.
COMPLT COMPLETE - (Explicit) - When a procedure is performed entirely through a previous incision. Applies to both the surgical and **anesthetic** components of health service codes.
PART PARTIAL - (Explicit) - When part of a procedure is performed through a previous incision. Applies to both the surgical and **anesthetic** components of health service codes.
REANE REANE ANAESTHESIA FOR RE-OPERATION - (Explicit) - For **specific ophthalmology re-operations,** a specified rate is paid in addition to the **anesthetic** benefit payable.
REOP REOP RE-OPERATION - (Explicit) - For **specific ophthalmology re-operations,** a specified rate is paid in addition to the procedure benefit payable. **Applies only to the surgical component of a health service code.**

SURC *Amend* the preamble to the SURC modifier to read:
SURC SERVICES UNSCHEDULED - (Explicit) - This modifier type is used for services listed in the **GRs** to indicate during which time period a service provider provided **unscheduled in-patient or out-patient services for a hospital service recipient.** A fee is added to the base rate as indicated by the modifier. For visits, refer to the subdivision modifier.

Delete RDEV, RDNTAM, RDNTPM and RDWK.

TELES *Add* **"physical therapist"** to modifier TELES.

SECTION OF ANESTHESIA

General Rules

GR 10.1 *Amend* GR 10.1 to read:
The appropriate listed **anesthetic** benefit or the number of time units for the procedure may be claimed when the oral surgical procedure is listed under the Schedule of Oral and **Maxillof**acial Surgery Benefits.

GR 12.3 *Amend* GR 12.3 to read:
In special cases where the attendance of more than one **anesthetist** is medically necessary, the benefit which may be claimed by each **anesthetist** shall be 100% of that listed for the procedure. **The decision as to whether a second anesthetist is required for a procedure lies with the primary anesthetist. In cases where the primary anesthetist determines a second anesthetist is required, claims from both anesthetists must be submitted with text explaining the necessity for two anesthetists.**

GR 12.4.7 *Amend* GR 12.4.7 to read:
Anesthesia services for oral surgical procedures insured under the Schedule of Oral and **Maxillof**acial Surgery Benefits will be paid according to GR6.9.

Health Service Codes

26.71 *Delete* modifiers BMIANT, ANEST and ANU from health service code 26.71. *Add* modifiers BMI2AN, 2ANES and 2ANU.

47.03A *Delete* modifiers BMIANT, ANU and ANEST from health service code 47.03A. *Add* modifiers ANE, BMIANE, 2ANES, 2ANU and BMI2AN.

52.12 *Add* modifier ANEU to health service code 52.12.

52.13 *Add* modifier ANEU to health service code 52.13.

52.42 *Add* modifier ANEU to health service code 52.42.

60.52A *Delete* modifiers BMIANT, ANU and ANEST from health service code 60.52A.

Add modifiers 2ANES, 2ANU and BMI2AN.

65.01C *Add* modifier ANEU to health service code 65.01C.

65.04C *Add* modifier ANEU to health service code 65.04C.

65.51 *Add* modifier ANEU to health service code 65.51.

65.9A *Add* modifier ANEU to health service code 65.9A.

65.9B *Add* modifier ANEU to health service code 65.9B.

67.11B *Add* modifier ANEU to health service code 67.11B.

68.2A *Add* modifier ANEU to health service code 68.2A.

93.45A *Add* modifier ANEU to health service code 93.45A.

93.96E *Delete* modifiers BMIANT, ANEST and ANU from health service code 93.96E.

Add modifiers BMI2AN, 2ANES and 2ANU.

96.01A *Amend* number of units (modifier ANEU) for health service code 96.01A to read:

1	For Each Call Pay Base At	100%
2-**8**	For Each Call Increase By	41.80

96.12B *Amend* number of units (modifier ANEU) for health service code 96.12B to read:

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

SECTION OF CARDIOLOGY

General Rules

GR 6.15.4 *Add* 49.7JA, 49.7KA, 49.7LA, 49.7MA to GR 6.15.4.

GR 11.2 *Amend* GR 11.2 to read:
A claim for **HSCs 03.52B, 03.52D, 03.55B and 03.56B** may be submitted by physicians who have been approved by the College of Physicians and Surgeons of Alberta **to provide these services**. For purposes of claims for HSC 03.52D, College of Physicians and Surgeons of Alberta approval for ECGs will be used as a proxy.

Health Service Codes

03.03FA *Amend* note 2 following health service code 03.03FA to read:
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, internal medicine,** medical genetics or physiatrists (no age restriction).

03.45A *Add* a health service code 03.45A:
Routine artificial pacemaker and ICD function check by a physician.....17.95
NOTE: May be claimed for remote interpretation.

Comment: When performed for hospital patients this service is the payment responsibility of the hospital or region.

03.45B *Add* a new health service code 03.45B:
Complex artificial pacemaker and ICD function check.....42.95
NOTE: 1. May be claimed for remote interpretation in cases where the physician spends at least 15 minutes interpreting data due to complex issues arising from implanted device i.e. syncope, shocks, etc.
2. May not be claimed for time spent setting up transmission or for difficulties in transmitting or receiving information.

49.7JA *Add* a new health service code 49.7JA:
Single chamber (right ventricular) implantable cardioverter defibrillator, insertion and testing 1050.00
NOTE: 1. May only be claimed by cardiologists or thoracic surgeons.
2. May not be claimed in addition to electrophysiology studies (HSCs 49.98F through 49.98Y).

49.7KA *Add* a new health service code 49.7KA:
Dual chamber implantable cardioverter defibrillator insertion and testing 1310.00
NOTE: 1. May only be claimed by cardiologists or thoracic surgeons.
2. May not be claimed in addition to electrophysiology studies (HSCs 49.98F through 49.98Y).

49.7LA *Add* a new health service code 49.7LA:
Cardiac resynchronization defibrillator insertion without arterial lead and testing 1750.00
NOTE: 1. May only be claimed by cardiologists or thoracic surgeons.
2. May not be claimed in addition to electrophysiology studies (HSCs 49.98F through 49.98Y).

49.7MA *Add* a new health service code 49.7MA:
Cardiac resynchronization defibrillator insertion and testing.....2012.00
NOTE: 1. May only be claimed by cardiologists or thoracic surgeons.
2. May not be claimed in addition to electrophysiology studies (HSCs 49.98F through 49.98Y).

49.7N *Add* a new health service code 49.7N:
Percutaneous venoplasty for lead placement.....600.00
NOTE: 1. May only be claimed by cardiologists or thoracic surgeons.
2. May be claimed in addition to HSCs 49.7 A, 49.7 F, 49.7 G, 49.7 H, 49.7JA, 49.7KA, 49.7LA and 49.7MA.

49.98Y *Amend* health service code 49.98Y to read:
Cardioversion
NOTE: 1. Any combination of **HSCs 49.98F through 49.98Y** may be claimed to a maximum of $**1,290.12** for diagnostic procedures.
2. **These are n**ot to be claimed in association with **HSCs** outside of **the** electrophysiology **studies (EPS)** section.
3. **These may only be claimed when performed in a hospital.**
4. **HSC** 49.98V may be claimed in association with diagnostic procedures to a maximum of $**1,344.97**.
5. **HSC** 49.98Y may only be claimed when performed with **EPS HSCs.** When it is not performed with EPS, then **HSC** 13.72A should be claimed.

SECTION OF CARDIOVASCULAR AND THORACIC SURGERY

Health Service Codes

49.7E *Add* modifiers REDO COMPLT, PART, REDO1, REDO2, REDO3, REDO4 and REDO5 to health service code 49.7E.

SECTION OF DERMATOLOGY AND DERMATOLOGIC SURGERY

Health Service Codes

98.12C *Amend* the notes following health service code 98.12C to read:
NOTE: 1. May be claimed in addition to a **visit or a consultation**.
2. **A maximum of 3 calls may be claimed**.

98.12G *Add* modifier UGA to health service code 98.12G.

98.12J *Add* note 1 to health service code 98.12J (current note becomes note 2):
1. May be claimed in addition to a visit or a consultation.

SECTION OF DIAGNOSTIC IMAGING

Health Service Codes

X27E *Amend* note 4 following health service code X27E to read:

4. X27C, X27D or X27E may not be claimed **subsequent to X27** within the same calendar year.

X88A *Amend* the note following X88A to read:

NOTE: If any of the above procedures **(HSCs X81 through X88A)** are **performed** without fluoroscopy the **benefit** should be reduced by $**10.16**.

X271 *Amend* note 1 following X271 to read:

1. Except where specified in Section X**,** stereo examinations increase the **benefit** by $**16.28**.

SECTION OF EMERGENCY MEDICINE

General Rules

GR 4.2.7 *Amend* GR 4.2.7 to read:
Comprehensive Visit in Emergency Department, AACC or UCC: An in-depth evaluation of a patient with a new or existing medical condition, including the recording of a complete history and a complete physical examination, and, where required, the ordering and reviewing of laboratory tests and x-rays and the initiation of appropriate therapy. May also be claimed for those patients whose illness or injury requires prolonged observation, continuous therapy and/or multiple reassessment(s) **or for patients presenting with obstetrical problems or gynecological bleeding who require an internal examination.** May be claimed by emergency medicine physicians, full-time emergency room physicians, general practitioners and pediatricians working a rotation duty shift in an emergency department with 24 hour on-site physician coverage or in an AACC or UCC with on-site coverage.

GR 5.1.1 *Amend* GR 5.1.1 to read:
HSCs 03.05CR, 03.05DR, 03.05ER, 03.05F, **03.05FA, 03.05FB** may only be claimed by physicians on rotation duty or by physicians who are providing first call coverage in an emergency department that has greater than 25,000 visits to the emergency room per year. **HSCs 03.05FR, 03.05GR, 03.05HR, 03.05FC, 03.05FD and 03.05FE may only be claimed by physicians on rotation duty in an AACC or UCC.**

GR 5.1.2 *Amend* GR 5.1.2 to read:
Only one of **HSCs 03.05CR, 03.05DR, 03.05ER, 03.05FR, 03.05GR or 03.05HR** may be claimed by either the same or a different physician, on the same date of service when the patient has remained in the emergency department, AACC or UCC.

GR 5.1.5 *Amend* GR 5.1.5 to read:
HSCs 13.99H and **13.99HA** may not be claimed in association with another visit **HSC**. Time units may be claimed on a cumulative basis.

GR 5.2.1 *Amend* GR 5.2.1 to read:
HSCs 03.03KA, 03.03LA, 03.03MC and **03.03MD** may be claimed when a physician is specially called from home or office to a hospital emergency department, AACC or UCC to attend one patient. **Maximums** apply, see GR 15.11.

GR 5.2.2 *Amend* GR 5.2.2 to read:
If a physician is in a hospital, AACC or UCC for any purpose and is asked to see another patient in the hospital emergency room or the same AACC or UCC, **HSCs 03.03KA, 03.03LA, 03.03MC, 03.03MD** do not apply. Benefits may be claimed for the applicable visit or procedure.

GR 5.2.3 *Delete* note a) and 03.03Z from note b) of GR 5.2.3.

GR 15.12 *Delete* GR 15.12.

GRs 15.12.1 to 15.12.9
Delete GRs 15.12.1, 15.12.2, 15.12.3, 15.12.4, 15.12.5, 15.12.6, 15.12.7, 15.12.8 and 15.12.9.

GR 15.13.3 *Delete* GR 15.13.3.

Health Service Codes

03.03K *Delete* health service code 03.03K.

03.03KA *Add* a new health service code 03.03KA:
Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, weekday, (0700-1700 hours).....64.58
NOTE: For auxiliary hospital and nursing home visits, refer to the notes following HSC 03.03MD.

03.03L *Delete* health service code 03.03L.

03.03LA *Add* a new health service code 03.03LA:
Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, weekday, (1700-2200 hours) or on Saturday, or statutory holiday (0700-2200 hours).....85.08
NOTE: For auxiliary hospital and nursing home visits, refer to the notes following HSC 03.03MD.

03.03MA *Delete* health service code 03.03MA.

03.03MB *Delete* health service code 03.03MB.

03.03MC *Add* a new health service code 03.03MC:
Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, any day (2200-2400 hours) 181.43
NOTE: For auxiliary hospital and nursing home visits, refer to the notes following HSC 03.03MD.

03.03MD *Add* a new health service code 03.03MD:
Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, any day (2400-0700 hours) 181.43
NOTE: For auxiliary hospital and nursing home visits

1. Benefits for HSCs 03.03KA, 03.03LA, 03.03MC, 03.03MD may only be claimed when the physician is requested to attend a patient, by the patient, the patient's relatives or the administrator of the facility.
2. For palliative care or acute inter-current illness, claim HSC 03.03D.
3. Benefits for HSCs 03.03KA, 03.03LA, 03.03MC, 03.03MD are payable based on the time at which the call for attendance is made and the physician responds on an unscheduled, priority basis.
4. Special callback benefits (HSCs 03.05N, 03.05P, 03.05QA, 03.05QB, 03.05R) may not be claimed in addition.
5. HSC 03.03EA may be claimed in addition for a callback to an auxiliary hospital or nursing home.
6. HSC 03.03DF may be claimed in addition to a callback where HSC 03.03D has been claimed for inter-current illness.

03.04F *Amend* health service code 03.04F to read:
Comprehensive visit in an emergency department, weekday, 0700-1700 hours
NOTE: Refer to the notes following HSC 03.04H.

03.04FA *Add* a new health service code 03.04FA:
Comprehensive visit in an AACC or UCC, weekday 0700-1700 hours 94.32
NOTE: Refer to the notes following HSC 03.04HA.

03.04G *Amend* health service code 03.04G to read:
Comprehensive visit in an emergency department, weekday, 1700-2200 hours or on Saturday, Sunday or statutory holiday, 0700-2200 hours
NOTE: Refer to the notes following HSC 03.04H.

03.04GA *Add* a new health service code 03.04GA:
Comprehensive visit in an AACC or UCC, weekday, 1700-2200 hours, or on Saturday, Sunday or statutory holiday 0700-2200 hours.....94.32
NOTE: Refer to the notes following HSC 03.04HA.

03.04H *Amend* health service code 03.04H to read:
Comprehensive visit in emergency department, 2200-0700 hours
NOTE:
1. **HSCs 03.04F, 03.04G, 03.04H may only be claimed by emergency medicine physicians, full time emergency room physicians, general practitioners or pediatricians working a rotation duty shift in an emergency department with 24 hour on-site coverage or by physicians who are providing first call coverage in an emergency department that has greater than 25,000 visits to the emergency room per year.**
2. **HSCs** 03.04F, 03.04G, 03.04H may be claimed for those patients whose illness/injury requires prolonged observation, continuous therapy and multiple reassessments as described in GR 4.2.7 **or for female patients requiring an internal examination because of obstetrical problems or gynecological bleeding.**

03.04HA *Add* a new health service code 03.04HA:
Comprehensive visit in an AACC or UCC, 2200-0700 hours 94.32
NOTE: 1. HSCs 03.04FA, 03.04GA, 03.04HA may only be claimed by physicians working a rotation duty shift in an AACC or UCC.
2. HSCs 03.04FA, 03.04GA, 03.04HA may be claimed for those patients whose illness/injury requires prolonged observation, continuous therapy and multiple reassessments as described in GR 4.2.7 or for female patients requiring an internal examination because of obstetrical problems or gynecological bleeding.

03.05CN *Delete* health service code 03.05CN.

03.05CR *Amend* health service code 03.05CR to read:
Rotation duty, **emergency department,** 0700-1700 hours
NOTE: Refer to the note following 03.05ER.

03.05DN *Delete* health service code 03.05DN.

03.05DR *Amend* health service code 03.05DR to read:
Rotation duty, **emergency department,** weekday, 1700-2200 hours or on Saturday, Sunday, or statutory holiday, 0700-2200 hours
NOTE: Refer to the note following 03.05ER.

03.05EN *Delete* health service code 03.05EN.

03.05ER *Amend* health service code 03.05ER to read:
Rotation duty**, emergency department**, 2200-0700 hours
NOTE: HSCs 03.05CR, 03.05DR and 03.05ER may only be claimed by physicians who are on-site and working a scheduled rotation duty shift in an emergency department, or are providing first call coverage in an emergency department with greater than 25,000 visits per year.

03.05F *Amend* health service code 03.05F to read:
Follow-up care of a patient remaining in an emergency department awaiting further evaluation, treatment, and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, weekday, 0700 to 1700 hours
NOTE: **Refer to the notes following HSC 03.05FB.**

03.05FA *Add* a new health service code 03.05FA:
Follow-up care of a patient remaining in an emergency department awaiting further evaluation, treatment and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, weekday, 1700 to 2200 hours, weekend and statutory holiday, 0700 to 2200 hours.....36.75
NOTE: Refer to the notes following HSC 03.05FB.

03.05FB *Add* a new health service code 03.05FB:
Follow-up care of a patient remaining in an emergency department awaiting further evaluation, treatment and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, any day, 2200 to 0700 hours 36.75
NOTE: 1. HSCs 03.05F, 03.05FA and 03.05FB may not be claimed on the same shift by the physician who provided the initial assessment.
2. HSCs 03.05F, 03.05FA and 03.05FB may only be claimed once per patient per emergency room shift.
3. HSCs 03.05F, 03.05FA and 03.05FB may only be claimed by physicians on rotation duty in an emergency department, or providing first call coverage in an emergency department with greater than 25,000 visits per year.
4. Should the patient remain in the emergency room awaiting an in-patient bed after admission to hospital, HSCs 03.05F, 03.05FA and 03.05FB may not be claimed by the emergency room physician.

03.05FC *Add* a new health service code 03.05FC:
Follow-up care of a patient remaining in an AACC or UCC, awaiting further evaluation, treatment, and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, weekday, 0700 to 1700 hours 36.75
NOTE: Refer to the notes following HSC 03.05FE.

03.05FD *Add* a new health service code 03.05FD:
Follow-up care of a patient remaining in an AACC or UCC awaiting further evaluation, treatment and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, weekday, 1700 to 2200 hours, weekend and statutory holiday, 0700 to 2200 hours.....36.75
NOTE: Refer to the notes following HSC 03.05FE.

03.05FE *Add* a new health service code 03.05FE:
Follow-up care of a patient remaining in an AACC or UCC awaiting further evaluation, treatment, transfer to another facility, or requiring extended care by a physician, any day, 2200 to 0700 hours.....36.75
NOTE: 1. HSCs 03.05FC, 03.05FD and 03.05FE may not be claimed on the same shift by the physician who provided the initial assessment.
2. HSCs 03.05FC, 03.05FD and 03.05FE may only be claimed once per patient per shift.
3. HSCs 03.05FC, 03.05FD and 03.05FE may only be claimed by physicians on rotation duty in an AACC or UCC.

03.05FF *Add* a new health service code 03.05FF:
Follow-up care of a patient remaining in a non-rotation duty emergency department after awaiting further evaluation, treatment, and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, 0700 – 1700 hours, weekdays 36.75
NOTE: Refer to the notes following HSC 03.05FH.

03.05FG *Add* a new health service code 03.05FG:
Follow-up care of a patient remaining in a non-rotation duty emergency department after awaiting further evaluation, treatment, and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician 1700 to 2200 hours, weekday, 0700 – 2200 hours weekend and statutory holiday 36.75
NOTE: Refer to the notes following 03.05FH.

03.05FH *Add* a new health service code 03.05FH:
Follow-up care of a patient remaining in a non-rotation duty emergency department after awaiting further evaluation, treatment, and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, 2200 to 0700 hours any day 36.75
NOTE: 1. May only be claimed by the same physician who provided the initial assessment when a second call for attendance has been made by staff or another physician.
2. May be claimed by a different physician who is taking over care of the patient.

03.05FR *Add* a new health service code 03.05FR:
Rotation duty, AACC or UCC, 0700-1700 hours 25.72
NOTE: Refer to the notes following HSC 03.05HR.

03.05GR *Add* a new health service code 03.05GR:
Rotation duty, AACC or UCC, weekday, 1700-2200 hours or on Saturday, Sunday or statutory holiday, 0700-2200 hours.....25.72
NOTE: Refer to the notes following HSC 03.05HR.

03.05HR *Add* a new health service code 03.05HR:
Rotation duty, AACC or UCC, 2200-0700 hours 25.72
NOTE: HSCs 03.05FR, 03.05GR and 03.05HR may only be claimed by physicians who are on-site and working in an AACC or UCC.

10.04B *Amend* note 2 following health service code 10.04B to read:
2. May not be claimed in addition to HSC 10.04, 13.99E or **13.99EA** when performed by the same physician.

13.99E *Amend* note 4 following health service code 13.99E to read:
4. 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, 13.99J, 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.**

13.99EA *Add* a new health service code 13.99EA:
Resuscitation in a AACC or UCC, first hour.....353.63
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. Each subsequent 15 minutes is payable at the rate specified in the Price List.
4. 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 13.99HA, 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.

13.99H *Amend* health service code 13.99H to read:
Critical care of severely ill or injured patient in a **hospital emergency department** requiring major treatment intervention(s), per 15 minutes

NOTE:
1. May only be claimed when a patient presents with a serious condition requiring at least a two hour stay in the active treatment portion of the **emergency department** or care results in hospitalization. The two hour period criterion does not apply in cases where the patient dies after having been seen.
2. **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.**
3. **Time spent providing services compensated elsewhere in the Schedule, e.g., family conferences and procedures, may not be included in time claimed for HSC 13.99H.**
4. Major treatment intervention is defined as a medical intervention which prevents or treats a condition that may result in significant morbidity.
5. A **surcharge** benefit may not be claimed for **HSC** 13.99H by a second physician who, due to a.shift change, has taken over care of a patient.

13.99HA *Add* a new health service code 13.99HA:
Critical care of severely ill or injured patient in an AACC or UCC department, or requiring major treatment intervention,
per 15 minutes.....50.22

NOTE:
1. May only be claimed when a patient presents with a serious condition requiring at least a two hour stay in the active treatment portion of the AACC or UCC or care results in hospitalization. The two hour period criterion does not apply in cases where the patient dies after having been seen.
2. 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.

3. Time spent providing services compensated elsewhere in the Schedule, e.g., family conferences and procedures, may not be included in time claimed for HSC 13.99HA.
4. Major treatment intervention is defined as a medical intervention which prevents or treats a condition that may result in significant morbidity.
5. A surcharge benefit may not be claimed for HSC 13.99HA by a second physician who, due to a shift change, has taken over care of a patient.

13.99J *Amend* note 1 and note 2 following health service code 13.99J to read:

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.**

Amend note 9 to read:

9. Only HSC 13.99J or procedures provided during the same encounter (with the exception of HSC 13.99E **and 13.99EA**) may be claimed, but not both. Concurrent **claims** for overlapping time for **the same or different** patient**s** may not be claimed.

13.99K *Amend* health service code 13.99K to read:
Ambulance detention time, per 15 minutes**, weekday, 0700 – 1700 hours**
NOTE: **Refer to the notes following HSC 13.99KB.**

13.99KA *Add* a new health service code 13.99KA:
Ambulance detention time, per 15 minutes, weekday, 1700 – 2200 hours, on Saturday, Sunday or statutory holiday, 0700-2200 hours.....104.27
NOTE: Refer to the notes following HSC 13.99KB.

13.99KB *Add* a new health service code 13.99KB:
Ambulance detention time, per 15 minutes, any day,
2200 – 0700 hours.....124.77
NOTE:
1. Supporting information must be submitted for HSCs 13.99K, 13.99KA and 13.99KB.
2. May be claimed by a physician during the time he/she is medically required to personally and continuously attend a patient being transported by surface or air ambulance.
3. Only time in attendance with the patient may be claimed.
4. Concurrent billing for overlapping time for separate patient encounters/services may not be claimed.
5. A maximum of 20 calls applies.

13.99V *Amend* health service code 13.99V to read:
Examination and crisis counselling**, per 15 minutes**
For sexual/physical abuse
NOTE: 1. **A maximum of 16 calls may be claimed**.
2. Time taken for forensic evidence is not to be included in total time.

13.99VA *Add* a new health service code 13.99VA:
Examination and crisis counselling for sexual/physical abuse in an AACC or UCC, per 15 minutes.....47.81
NOTE: 1. A maximum of 16 calls may be claimed.
2. Time taken for forensic evidence is not to be included in total time.

35.0A *Amend* the note following health service code 35.0A to read:
NOTE: May be claimed when performed by a physician on an emergency basis **or when required as part of surgical repair of fractured mandible.**

91.71 *Add* a note to health service code 91.71:
NOTE: May not be claimed for dislocated radial head.

98.03D *Add* a new health service code 98.03D:
Abscess requiring procedural sedation and extensive drainage and packing 100.00
NOTE: May only be claimed when performed in an emergency room, AACC or UCC.

SECTION OF ENDOCRINOLOGY AND METABOLISM

Health Service Codes

03.03AO *Amend* note 1 following health service code 03.03AO to read:

1. May only be claimed by **endocrinology/metabolism,** general internal medicine, hematology, clinical immunology, medical oncology, orthopedics and respiratory medicine.

Modifiers

CMXV15 *Amend* the last bullet following modifier CMXV15 to read:

- cardiology, **endocrinology/metabolism,** haematology, infectious diseases, internal medicine, medical oncology, nephrology, pediatric cardiology, **pediatrics** for HSCs 03.03A, 03.03F, 03.07A, 03.07B. **Pediatrics may claim for HSC 03.05JK.**

CMXV30 *Amend* the last bullet following modifier CMXV30 to read:

- cardiology, **endocrinology/metabolism,** haematology, infectious diseases, internal medicine, medical oncology, nephrology, pediatric cardiology**, pediatrics** for HSCs 03.03A, 03.03F, 03.07A, 03.07B.
Pediatrics may claim for HSC 03.05JK.

SECTION OF GASTROENTEROLOGY

Health Service Codes

01.14 *Add* 13.99AF to note 1 following health service code 01.14.

01.22 *Amend* health service code 01.22 to read:
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. Refer to HSCs 01.22A, 01.22B and 01.22C for screening.

01.22A *Add* 57.21C to note 1 following health service code 01.22A.

01.22B *Add* 57.21C to note 1 following health service code 01.22B.

Amend notes 4 and 5 to read:
4. 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.
5. May be claimed **once** every 5 years.

01.22C *Add* 57.21C to note 1 following health service code 01.22C.

01.24BA *Amend* health service code 01.24BA to read:
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. HSC 58.99D may be claimed in addition.
2. Benefit includes biopsies and/or polypectomies.
3. May be claimed **once every** year beginning at the age of 10.

01.24BB *Amend* health service code 01.24BB to read:
Flexible proctosigmoidoscopy for screening of **patients who are considered to be of average risk for colon cancer**
NOTE: 1. HSC 58.99D may be claimed in addition.
2. Benefit includes biopsies and/or polypectomies.
3. Average risk is defined as an individual who is asymptomatic and aged 50 to 74 years.
4. May be claimed **once** every 5 years.

03.08I *Amend* health service code 03.08I to read:
Prolonged **gastroenterology, internal medicine,** physiatry or neurology consultation, per 15 minutes
NOTE: May only be claimed in addition to HSC 03.08A for consultations exceeding **30** minutes.

13.99AC *Amend* note 4 following health service code 13.99AC to read:

4. **HSC 03.03AR , 03.03DF and s**pecial callback benefits (**HSCs** 03.05N, 03.05P, 03.05QA, 03.05QB, 03.05R) may be claimed in the same calendar week for the same patient by the same physician.

13.99AE *Add* a new health service code 13.99AE:

Placement of colonic stent via colonoscope, additional benefit 200.00
NOTE: May only be claimed in addition to HSC 01.22.

13.99AF *Add* a new health service code 13.99AF:

Placement of duodenal stent via gastroscope, additional benefit.....200.00
NOTE: May only be claimed in addition to HSCs 01.14 or 64.97A.

57.13A *Amend* note 1 following health service code 57.13A to read:

1. May only be claimed in addition to **HSCs** 01.22, **01.22A, 01.22B and 01.22C**.

57.21A *Amend* note 1 following health service code 57.21A to read:

1. May only be claimed with **HSCs** 01.22, **01.22A, 01.22B and 01.22C** and when the removal of a colonic muscosal lesion is performed using a polypectomy snare (with or without **electrocautery**) or a hot biopsy forcep.

57.21B *Amend* note 3 following health service code 57.21B to read:

3. May only be claimed in addition to **HSCs** 01.22**, 01.22A, 01.22B and 01.22C**.

Add a new note 4:

4. May be claimed in addition to HSC 57.21C if polyps are removed from a different site.

57.21C *Add* a new health service code 57.21C:

Removal of sessile polyp via colonoscope, additional benefit.....175.00
NOTE:
1. May only be claimed for polyps greater than 2 cms in size requiring submucosal injection and piecemeal resection.
2. May only be claimed in addition to HSCs 01.22, 01.22A, 01.22B, 01.22C.
3. May be claimed in addition to HSC 57.21A if polyps are removed from different sites.
4. May not be claimed for pedunculated polyps.
5. A maximum of two calls applies.

58.99C *Amend* note 1 following health service code 58.99C to read:

1. May only be claimed in addition to **HSCs** 01.22**, 01.22A, 01.22B and 01.22C**.

58.99D *Amend* note 1 following health service code 58.99D to read:

1. May only be claimed in addition to **HSCs** 01.24A**,** 01.24B**, 01.24BA and 01.24BB**.

63.88 *Amend* health service code 63.88 to read:
Endoscopic pancreatic stent placement or insertion of stent into bile duct**, additional benefit**
NOTE: 1. May not be claimed in addition to **HSC** 63.87.
2. May only be claimed in addition to **HSC** 64.97A.

64.97A *Amend* the note following health service code 64.97A to read:
NOTE: May be claimed in addition to **HSCs 13.99AF,** 63.86A, 63.87, 63.88, 63.90A, and 63.90B.

SECTION OF GENERAL PRACTICE

General Rules

GR 4.2.7 *Amend* GR 4.2.7 to read:
Comprehensive Visit in Emergency Department, AACC or UCC: An in-depth evaluation of a patient with a new or existing medical condition, including the recording of a complete history and a complete physical examination, and, where required, the ordering and reviewing of laboratory tests and x-rays and the initiation of appropriate therapy. May also be claimed for those patients whose illness or injury requires prolonged observation, continuous therapy and/or multiple reassessment(s) **or for patients presenting with obstetrical problems or gynecological bleeding who require an internal examination.** May be claimed by emergency medicine physicians, full-time emergency room physicians, general practitioners and pediatricians working a rotation duty shift in an emergency department with 24 hour on-site physician coverage or in an AACC or UCC with on-site coverage.

GR 5.1.1 *Amend* GR 5.1.1 to read:
HSCs 03.05CR, 03.05DR, 03.05ER, 03.05F, **03.05FA, 03.05FB** may only be claimed by physicians on rotation duty or by physicians who are providing first call coverage in an emergency department that has greater than 25,000 visits to the emergency room per year. **HSCs 03.05FR, 03.05GR, 03.05HR, 03.05FC, 03.05FD and 03.05FE may only be claimed by physicians on rotation duty in an AACC or UCC.**

GR 5.1.2 *Amend* GR 5.1.2 to read:
Only one of **HSCs 03.05CR, 03.05DR, 03.05ER, 03.05FR, 03.05GR or 03.05HR** may be claimed by either the same or a different physician, on the same date of service when the patient has remained in the emergency department, AACC or UCC.

GR 5.1.5 *Amend* GR 5.1.5 to read:
HSCs 13.99H and **13.99HA** may not be claimed in association with another visit **HSC**. Time units may be claimed on a cumulative basis.

GR 5.2.1 *Amend* GR 5.2.1 to read:
HSCs 03.03KA, 03.03LA, 03.03MC and **03.03MD** may be claimed when a physician is specially called from home or office to a hospital emergency department, AACC or UCC to attend one patient. **Maximums** apply, see GR 15.11.

GR 5.2.2 *Amend* GR 5.2.2 to read:
If a physician is in a hospital, AACC or UCC for any purpose and is asked to see another patient in the hospital emergency room or the same AACC or UCC, **HSCs 03.03KA, 03.03LA, 03.03MC, 03.03MD** do not apply. Benefits may be claimed for the applicable visit or procedure.

GR 5.2.3 *Delete* note a) and 03.03Z from note b) of GR 5.2.3.

GR 15.12 *Delete* GR 15.12.

GRs 15.12.1 to 15.12.9
Delete GRs 15.12.1, 15.12.2, 15.12.3, 15.12.4, 15.12.5, 15.12.6, 15.12.7, 15.12.8 and 15.12.9.

GR 15.13.3 *Delete* GR 15.13.3.

Health Service Codes

03.01LM *Add* a new health service code 03.01LM:
Patient care advice to active treatment facility worker or nurse practitioner in relation to the obstetrical outpatient, weekdays 0700 – 1700 hours.....16.95
NOTE: Refer to the notes following HSC 03.01LO.

03.01LN *Add* a new health service code 03.01LN:
Patient care advice to active treatment facility worker or nurse practitioner in relation to the obstetrical outpatient, weekdays 1700 – 2200 hours, weekends and statutory holidays 0700 – 2200 hours 25.03
NOTE: Refer to the notes following HSC 03.01LO.

03.01LO *Add* a new health service code 03.01LO:
Patient care advice to active treatment facility worker or nurse practitioner in relation to the obstetrical outpatient, any day 2200 – 0700 hours 29.54
NOTE:
1. Active treatment facility worker may include Registered Nurse, Licensed Practical Nurse, midwife.
2. To be claimed using the Personal Health Number of the patient.
3. May only be claimed by general practice or obstetrics and gynecology.
4. 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.
5. May only be claimed when the physician is outside the facility from where the patient is located.
6. May only be claimed when the call is initiated by the active treatment facility worker or nurse practitioner.
7. May only be claimed for advice given to the active treatment facility worker or nurse practitioner by telephone or other telecommunication means.
8. A maximum of two (any combination of HSC 03.01LM, 03.01LN or 03.01LO) may be claimed per patient, per physician, per day.
9. Documentation of the communication must be recorded in their respective records.

03.03A *Add* the following note to health service code 03.03A:
NOTE: May be claimed in addition to HSC 03.04J.

Comment: There has been an increase to the rate for patients 75 years of age or greater for general practice only. This rate increase replaces 03.03Z which has been deleted. Claims submitted by general practice physicians for patients within this age group will see an automatic increase to the rate as a result of an implicit age modifier.

03.03E *Amend* note 2 following health service code 03.03E to read:
2. **HSC 03.03EA and** special callbacks (HSCs 03.03AR, **03.03KA, 03.03LA, 03.03MC, 03.03MD**) may be claimed subsequent to a 03.03E in the same calendar week for the same patient by the same physician.

03.03EA *Add* a new health service code 03.03EA:
Visit to long term care patient in association with a special callback (HSC 03.03KA, 03.03LA, 03.03MC, 03.03MD).....25.89

03.03K *Delete* health service code 03.03K.

03.03KA *Add* a new health service code 03.03KA
Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, weekday, (0700-1700 hours).....64.58
NOTE: For auxiliary hospital and nursing home visits, refer to the notes following HSC 03.03MD.

03.03L *Delete* health service code 03.03L

03.03LA *Add* a new health service code 03.03LA:
Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, weekday, (1700-2200 hours) or on Saturday, or statutory holiday (0700-2200 hours).....85.08
NOTE: For auxiliary hospital and nursing home visits, refer to the notes following HSC 03.03MD.

03.03MA *Delete* health service code 03.03MA.

03.03MB *Delete* health service code 03.03MB.

03.03MC *Add* a new health service code 03.03MC:
Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, any day (2200-2400 hours) 181.43
NOTE: For auxiliary hospital and nursing home visits, refer to the notes following HSC 03.03MD.

03.03MD *Add* a new health service code 03.03MD:
Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, any day (2400-0700 hours) 181.43
NOTE: For auxiliary hospital and nursing home visits

1. Benefits for HSCs 03.03KA, 03.03LA, 03.03MC, 03.03MD may only be claimed when the physician is requested to attend a patient, by the patient, the patient's relatives or the administrator of the facility.
2. For palliative care or acute inter-current illness, claim HSC 03.03D.
3. Benefits for HSCs 03.03KA, 03.03LA, 03.03MC, 03.03MD are payable based on the time at which the call for attendance is made and the physician responds on an unscheduled, priority basis.
4. Special callback benefits (HSCs 03.05N, 03.05P, 03.05QA, 03.05QB, 03.05R) may not be claimed in addition.
5. HSC 03.03EA may be claimed in addition for a callback to an auxiliary hospital or nursing home.
6. HSC 03.03DF may be claimed in addition to a callback where HSC 03.03D has been claimed for inter-current illness.

03.03N *Add* a note to health service code 03.03N:
NOTE: May be claimed in addition to HSC 03.04J.

03.03Z *Delete* health service code 03.03Z.

Comment: The rate for 03.03A has been increased for patients 75 years of age or older for general practice only to account for the deletion of this health service code.

03.04F *Amend* health service code 03.04F to read:
Comprehensive visit in an emergency department, weekday, 0700-1700 hours
NOTE: Refer to the notes following HSC 03.04H.

03.04FA *Add* a new health service code 03.04FA:
Comprehensive visit in an AACC or UCC, weekday 0700-1700 hours 94.32
NOTE: Refer to the notes following HSC 03.04HA.

03.04G *Amend* health service code 03.04G to read:
Comprehensive visit in an emergency department, weekday, 1700-2200 hours or on Saturday, Sunday or statutory holiday, 0700-2200 hours
NOTE: Refer to the notes following HSC 03.04H.

03.04GA *Add* a new health service code 03.04GA:
Comprehensive visit in an AACC or UCC, weekday, 1700-2200 hours, or on Saturday, Sunday or statutory holiday 0700-2200 hours.....94.32
NOTE: Refer to the notes following HSC 03.04HA.

03.04H *Amend* health service code 03.04H to read:
Comprehensive visit in emergency department, 2200-0700 hours
NOTE: 1. **HSCs 03.04F, 03.04G, 03.04H may only be claimed by emergency medicine physicians, full time emergency room physicians, general practitioners or pediatricians working a rotation duty shift in an emergency department with 24 hour on-site coverage or by physicians who are providing first call coverage in an emergency department that has greater than 25,000 visits to the emergency room per year.**
2. **HSCs** 03.04F, 03.04G, 03.04H may be claimed for those patients whose illness/injury requires prolonged observation, continuous therapy and multiple reassessments as described in GR 4.2.7 **or for female patients requiring an internal examination because of obstetrical problems or gynecological bleeding.**

03.04HA *Add* a new health service code 03.04HA:
Comprehensive visit in an AACC or UCC, 2200-0700 hours 94.32
NOTE: 1. HSCs 03.04FA, 03.04GA, 03.04HA may only be claimed by physicians working a rotation duty shift in an AACC or UCC.
2. HSCs 03.04FA, 03.04GA, 03.04HA may be claimed for those patients whose illness/injury requires prolonged observation, continuous therapy and multiple reassessments as described in GR 4.2.7 or for female patients requiring an internal examination because of obstetrical problems or gynecological bleeding.

03.04J *Add* a new health service code 03.04J:
Development, documentation and administration of a comprehensive annual care plan for a patient with complex needs 206.70
NOTE: 1. May only be claimed by the most responsible primary care general practitioner.
2. 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. May be claimed in addition to HSCs 03.03A, 03.03N, 03.04A or 03.04K.
4. Time spent on the preparation of the complex care plan may not be included in the time requirement for a complex modifier.
5. "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
- Chronic Obstructive Pulmonary Disease	- Addictions
- Asthma	- Tobacco
- Heart Failure	
- Ischaemic Heart Disease	

6. "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 (agent as defined in the *Personal Directives Act* {RSA 2007c37s3}).
   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.

03.04K *Add* a new health service code 03.04K:
Comprehensive geriatric assessment, first hour and 30 minutes.....300.00
NOTE: 1. If the assessment is less than 1 hour and 30 minutes, then HSC 03.04A or 03.08A should be claimed.
2. May only be claimed when performed in a regional facility.
3. May only be claimed for patients aged 75 years or older.
4. May only be claimed by general practitioners, internal medicine specialists or geriatric medicine specialists.
5. May be claimed in addition to HSC 03.04J.
6. May only be claimed once per patient per year.
7. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List, to a maximum of 6 calls.
8. Assessment must include the following components:
   a) Medical includes but is not limited to a complete physical examination, a problem list, co morbidity conditions and disease severity, a medication review and nutritional status.

b) Functional includes but is not limited to a review of basic activities of daily living, instrumental activities of daily living, activity/ exercise status, gait and balance.
c) Cognitive/psychological includes but is not limited to review of mental status, administration of the Mini Mental State Examination (MMSE) and mood/depression testing through Geriatric Depression Scale (GDS).
d) Social includes but is not limited to a review of informal support needs and assets, care resource eligibility and a financial assessment.
e) Environmental includes but is not limited to a review of current living situation, home safety and transportation.

03.05CN *Delete* health service code 03.05CN.

03.05CR *Amend* health service code 03.05CR to read:
Rotation duty, **emergency department,** 0700-1700 hours
NOTE: Refer to the note following 03.05ER.

03.05DN *Delete* health service code 03.05DN.

03.05DR *Amend* health service code 03.05DR to read:
Rotation duty, **emergency department,** weekday, 1700-2200 hours or on Saturday, Sunday, or statutory holiday, 0700-2200 hours
NOTE: Refer to the note following 03.05ER.

03.05EN *Delete* health service code 03.05EN.

03.05ER *Amend* health service code 03.05ER to read:
Rotation duty**, emergency department**, 2200-0700 hours
NOTE: HSCs 03.05CR, 03.05DR and 03.05ER may only be claimed by physicians who are on-site and working a scheduled rotation duty shift in an emergency department, or are providing first call coverage in an emergency department with greater than 25,000 visits per year.

03.05F *Amend* health service code 03.05F to read:
Follow-up care of a patient remaining in an emergency department awaiting further evaluation, treatment, and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, weekday, 0700 to 1700 hours
NOTE: **Refer to the notes following HSC 03.05FB.**

03.05FA *Add* a new health service code 03.05FA:
Follow-up care of a patient remaining in an emergency department awaiting further evaluation, treatment and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, weekday, 1700 to 2200 hours, weekend and statutory holiday, 0700 to 2200 hours.....36.75
NOTE: Refer to the notes following HSC 03.05FB.

03.05FB *Add* a new health service code 03.05FB:
Follow-up care of a patient remaining in an emergency department awaiting further evaluation, treatment and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, any day, 2200 to 0700 hours 36.75
NOTE: 1. HSCs 03.05F, 03.05FA and 03.05FB may not be claimed on the same shift by the physician who provided the initial assessment.
2. HSCs 03.05F, 03.05FA and 03.05FB may only be claimed once per patient per emergency room shift.
3. HSCs 03.05F, 03.05FA and 03.05FB may only be claimed by physicians on rotation duty in an emergency department, or providing first call coverage in an emergency department with greater than 25,000 visits per year.
4. Should the patient remain in the emergency room awaiting an in-patient bed after admission to hospital, HSCs 03.05F, 03.05FA and 03.05FB may not be claimed by the emergency room physician.

03.05FC *Add* a new health service code 03.05FC:
Follow-up care of a patient remaining in an AACC or UCC, awaiting further evaluation, treatment, and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, weekday, 0700 to 1700 hours 36.75
NOTE: Refer to the notes following HSC 03.05FE.

03.05FD *Add* a new health service code 03.05FD:
Follow-up care of a patient remaining in an AACC or UCC awaiting further evaluation, treatment and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, weekday, 1700 to 2200 hours, weekend and statutory holiday, 0700 to 2200 hours.....36.75
NOTE: Refer to the notes following HSC 03.05FE.

03.05FE *Add* a new health service code 03.05FE:
Follow-up care of a patient remaining in an AACC or UCC awaiting further evaluation, treatment, transfer to another facility, or requiring extended care by a physician, any day, 2200 to 0700 hours.....36.75
NOTE: 1. HSCs 03.05FC, 03.05FD and 03.05FE may not be claimed on the same shift by the physician who provided the initial assessment.
2. HSCs 03.05FC, 03.05FD and 03.05FE may only be claimed once per patient per shift.
3. HSCs 03.05FC, 03.05FD and 03.05FE may only be claimed by physicians on rotation duty in an AACC or UCC.

03.05FF *Add* a new health service code 03.05FF:
Follow-up care of a patient remaining in a non-rotation duty emergency department after awaiting further evaluation, treatment, and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, 0700 – 1700 hours, weekdays 36.75
NOTE: Refer to the notes following HSC 03.05FH.

03.05FG *Add* a new health service code 03.05FG:
Follow-up care of a patient remaining in a non-rotation duty emergency department after awaiting further evaluation, treatment, and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician 1700 to 2200 hours, weekday, 0700 – 2200 hours weekend and statutory holiday 36.75
NOTE: Refer to the notes following 03.05FH.

03.05FH *Add* a new health service code 03.05FH:
Follow-up care of a patient remaining in a non-rotation duty emergency department after awaiting further evaluation, treatment, and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician 2200 to 0700 hours any day 36.75
NOTE: 1. May only be claimed by the same physician who provided the initial assessment when a second call for attendance has been made by staff or another physician.
2. May be claimed by a different physician who is taking over care of the patient.

03.05FR *Add* a new health service code 03.05FR:
Rotation duty, AACC or UCC, 0700-1700 hours 25.72
NOTE: Refer to the notes following HSC 03.05HR.

03.05GR *Add* a new health service code 03.05GR:
Rotation duty, AACC or UCC, weekday, 1700-2200 hours or on Saturday, Sunday or statutory holiday, 0700-2200 hours.....25.72
NOTE: Refer to the notes following HSC 03.05HR.

03.05HR *Add* a new health service code 03.05HR:
Rotation duty, AACC or UCC, 2200-0700 hours 25.72
NOTE: HSCs 03.05FR, 03.05GR and 03.05HR may only be claimed by physicians who are on-site and working in an AACC or UCC.

10.04B *Amend* note 2 following health service code 10.04B to read:
2. May not be claimed in addition to HSC 10.04, 13.99E or **13.99EA** when performed by the same physician.

13.99EA *Add* a new health service code 13.99EA:
Resuscitation in a AACC or UCC, first hour.....353.63
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. Each subsequent 15 minutes is payable at the rate specified in the Price List.

4. 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 13.99HA, 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.

13.99H *Amend* health service code 13.99H to read:
Critical care of severely ill or injured patient in a **hospital emergency department** requiring major treatment intervention(s), per 15 minutes

NOTE:
1. May only be claimed when a patient presents with a serious condition requiring at least a two hour stay in the active treatment portion of the **emergency department** or care results in hospitalization. The two hour period criterion does not apply in cases where the patient dies after having been seen.
2. **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.**
3. **Time spent providing services compensated elsewhere in the Schedule, e.g., family conferences and procedures, may not be included in time claimed for HSC 13.99H.**
4. Major treatment intervention is defined as a medical intervention which prevents or treats a condition that may result in significant morbidity.
5. A **surcharge** benefit may not be claimed for **HSC** 13.99H by a second physician who, due to a.shift change, has taken over care of a patient.

13.99HA *Add* a new health service code 13.99HA:
Critical care of severely ill or injured patient in an AACC or UCC department, or requiring major treatment intervention,
per 15 minutes.....50.22

NOTE:
1. May only be claimed when a patient presents with a serious condition requiring at least a two hour stay in the active treatment portion of the AACC or UCC or care results in hospitalization. The two hour period criterion does not apply in cases where the patient dies after having been seen.
2. 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.
3. Time spent providing services compensated elsewhere in the Schedule, e.g., family conferences and procedures, may not be included in time claimed for HSC 13.99HA.
4. Major treatment intervention is defined as a medical intervention which prevents or treats a condition that may result in significant morbidity.

5. A surcharge benefit may not be claimed for HSC 13.99HA by a second physician who, due to a shift change, has taken over care of a patient.

13.99K *Amend* health service code 13.99K to read:
Ambulance detention time, per 15 minutes**, weekday, 0700 – 1700 hours**
NOTE: **Refer to the notes following HSC 13.99KB.**

13.99KA *Add* a new health service code 13.99KA:
Ambulance detention time, per 15 minutes, weekday, 1700 – 2200 hours, on Saturday, Sunday or statutory holiday, 0700-2200 hours.....104.27
NOTE: Refer to the notes following HSC 13.99KB.

13.99KB *Add* a new health service code 13.99KB:
Ambulance detention time, per 15 minutes, any day, 2200 – 0700 hours.....124.77
NOTE: 1. Supporting information must be submitted for HSCs 13.99K, 13.99KA and 13.99KB.
2. May be claimed by a physician during the time he/she is medically required to personally and continuously attend a patient being transported by surface or air ambulance.
3. Only time in attendance with the patient may be claimed.
4. Concurrent billing for overlapping time for separate patient encounters/services may not be claimed.
5. A maximum of 20 calls applies.

13.99VA *Add* a new health service code 13.99VA:
Examination and crisis counselling for sexual/physical abuse in an AACC or UCC, per 15 minutes.....47.81
NOTE: 1. A maximum of 16 calls may be claimed.
2. Time taken for forensic evidence is not to be included in total time.

51.92A *Amend* health service code 51.92A to read:
Varicose vein, single injection
NOTE: 1. Sclerotherapy for asymptomatic varicose veins is not an insured service.
2. At any one visit, a maximum of three **HSC** 51.92B may be claimed in addition to a 51.92A.
3. A maximum of six **HSC** 51.92A and eighteen 51.92B may be claimed per benefit year.
4. May be claimed in addition to a visit or a consultation.

Comment: The rate for health service code 51.92A has been reduced and the repeat modifier deleted as this code can now be claimed with a visit or a consultation.

91.71 *Add* a note to health service code 91.71:
NOTE: May not be claimed for dislocated radial head.

98.03D *Add* a new health service code 98.03D:
Abscess requiring procedural sedation and extensive drainage and packing 100.00
NOTE: May only be claimed when performed in an emergency room, AACC or UCC.

98.12C *Amend* the notes following health service code 98.12C to read:
NOTE: 1. May be claimed in addition to a **visit or a consultation**.
2. **A maximum of 3 calls may be claimed**.

98.12J *Add* note 1 to health service code 98.12J (current note becomes note 2):
1. May be claimed in addition to a visit or a consultation.

Modifiers

AGE *Add* the following to the AGE modifier:
G75GP OVER 75 YEARS - (Implicit) - The patient is 75 years of age or older. This modifier allows physicians with the skill of GP to be paid for HSC 03.03A at 20% above the GP rate.

CALL *Add* a new modifier to CALL CALLS UNITS:
COMGER – COMPREHENSIVE GERIATRIC ASSESSMENT PER 1 1/2 HOURS + EACH ADDITIONAL 1/4 HOUR – (Implicit) – First unit represents 1 ½ hours, each subsequent unit represents 15 minutes.

CMPX *Add* a new modifier CMPX:
CMPX COMPLEX TIME – (Explicit) – This modifier type is used to indicate a complex patient visit payable in time units.
CMGP COMPLEX PATIENT VISIT - (Explicit) - This modifier is used to indicate a complex patient visit requiring that the physician spend 15 minutes or more on management of the patient's care. **EACH ADDITIONAL UNIT REPRESENTS 10 MINUTES. ADDITIONAL UNITS MAY NOT BE CLAIMED UNLESS A FULL 10 MINUTES HAS ELAPSED.** (Example: CMGP03 indicates a general practice physician has spent a minimum of 35 minutes with the patient. The first unit represents 15 minutes and each subsequent unit represents 10 minutes.) A maximum of 6 calls may be claimed.

May only be claimed by general practice for HSCs 03.03A, 03.03B, 03.03C, 03.07A, 03.07B.

Comment: Modifier CMGP is restricted to GP. A system rule to prevent GP from using modifiers CMXV15 and CMXV30 will be implemented.

SECTION OF GENERAL PSYCHIATRY

Health Service Codes

08.11C *Add* a new health service code 08.11C:
For complex patient, requiring complete mental status examination and investigation, first hour 171.17

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.

Comment: Not payable more than once every 180 days.

08.19GB *Add* a new health service code 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 57.05

NOTE:
1. May only be claimed by a psychiatrist.
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.

08.38 *Amend* note 1 and note 2 following health service code 08.38 to read:
1. May be claimed with a maximum of two HSC 08.19G**,** 08.19GA **or 08.19GB** if appropriate.
2. In order to claim HSC 08.38 and 08.19G**,** 08.19GA **or 08.19GB** for the same date of service, one hour must have elapsed.

08.44C *Add* a new health service code 08.44C:
Group psychotherapy, complex group, where all members of the group are receiving therapy in the session, per 15 minutes 71.89
NOTE: 1. May only be claimed by a psychiatrist.
2. May only be claimed for groups where one or more of the members has a significant personality disorder.

08.44D *Add* a new health service code 08.44D:
Second physician attendance at complex group psychotherapy, where all members of the group are receiving therapy in the session, per 15 minutes.....71.89
NOTE: 1. May only be claimed by a psychiatrist.
2. May only be claimed for groups where one or more of the members has a significant personality disorder.

08.45A *Add* a new health service code 08.45A:
Complex assessment or therapy of a family, requiring comprehensive psychiatric or family systems evaluation, first 45 minutes 190.01
NOTE: 1. May only be claimed by psychiatrists.
2. May only be claimed for family therapy where one or more members of the family has a significant personality disorder.
3. May only be claimed when the purpose of the visit is to provide psychiatric assessment or therapy to deal with systemic issues in the family unit.
4. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List.

SECTION OF GENERAL SURGERY

Health Service Codes

03.05B *Amend* health service code 03.05B to read:
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** 13.99G.
2. May only be claimed by the co-coordinating surgical specialist.
3. May not be claimed in addition to a major surgical procedure performed by the same (trauma) physician.
4. May be claimed for referred cases only.
5. Following the **fourteenth** day of trauma care, claims should be submitted for the appropriate level of hospital care.
6. Trauma care may be claimed in addition to care provided by intensivists.

Amend modifier NBRDAY to read:
CALL NBRDAY V
1-**14** For Each Call Pay Base At 100%

50.99F *Add* health service code 50.99F:
Removal and reinsertion of long dwelling intravascular catheter requiring subcutaneous tunnel under general anesthesia.....307.31

50.99G *Add* health service code 50.99G:
Removal of long dwelling intravascular catheter requiring subcutaneous tunnel under general anesthesia.....129.05

52.12 *Add* modifier NBRSER to health service code 52.12.

52.13 *Add* modifier NBRSER to health service code 52.13.

52.42 *Add* modifier NBRSER to health service code 52.42.

55.8A *Add* a note to health service code 55.8A:
NOTE: May be claimed in addition to HSC 66.83.

55.8B *Add* a note to health service code 55.8B:
NOTE: May be claimed in addition to HSC 66.83.

55.8C *Add* a note to health service code 55.8C:
NOTE: May be claimed in addition to HSC 66.83.

55.8D *Add* a note to health service code 55.8D:
NOTE: May be claimed in addition to HSC 66.83.

55.9A *Add* a note to health service code 55.9A:
NOTE: May be claimed in addition to HSC 66.83.

55.9B *Add* a note to health service code 55.9B:
NOTE: May be claimed in addition to HSC 66.83.

55.9C *Add* a note to health service code 55.9C:
NOTE: May be claimed in addition to HSC 66.83.

55.99A *Add* a note to health service code 55.99A:
NOTE: May be claimed in addition to HSC 66.83.

57.13A *Amend* note 1 following health service code 57.13A to read:
1. May only be claimed in addition to **HSCs** 01.22, **01.22A, 01.22B and 01.22C**.

57.21A *Amend* note 1 following health service code 57.21A to read:
1. May only be claimed with **HSCs** 01.22, **01.22A, 01.22B and 01.22C** and when the removal of a colonic muscosal lesion is performed using a polypectomy snare (with or without **electrocautery**) or a hot biopsy forcep.

57.21B *Amend* note 3 following health service code 57.21B to read:
3. May only be claimed in addition to **HSCs** 01.22**, 01.22A, 01.22B and 01.22C**.

Add a new note 4:
4. May be claimed in addition to HSC 57.21C if polyps are removed from a different site.

57.21C *Add* a new health service code 57.21C:
Removal of sessile polyp via colonoscope, additional benefit.....175.00
NOTE: 1. May only be claimed for polyps greater than 2 cms in size requiring submucosal injection and piecemeal resection.
2. May only be claimed in addition to HSCs 01.22, 01.22A, 01.22B, 01.22C.
3. May be claimed in addition to HSC 57.21A if polyps are removed from different sites.
4. May not be claimed for pedunculated polyps.
5. A maximum of two calls applies.

63.88 *Amend* health service code 63.88 to read:
Endoscopic pancreatic stent placement or insertion of stent into bile duct**, additional benefit**
NOTE: 1. May not be claimed in addition to **HSC** 63.87.
2. May only be claimed in addition to **HSC** 64.97A.

64.43A *Add* a note to health service code 64.43A:
NOTE: May be claimed in addition to HSC 66.83.

64.49 *Add* a note to health service code 64.49:
NOTE: May be claimed in addition to HSC 66.83.

64.81A *Add* a new health service code 64.81A:
Pancreatic transplant and back table preparation 2820.00

64.81B *Add* a new health service code 64.81B:
Donor pancreas removal 1245.00
NOTE: To be claimed under the recipient PHN.

64.97A *Amend* the note following health service code 64.97A to read:
NOTE: May be claimed in addition to **HSCs 13.99AF,** 63.86A, 63.87, 63.88, 63.90A, and 63.90B.

65.01C *Add* modifier NBRSER to health service code 65.01C.

65.04B *Amend* modifier NBRSER to read:

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

65.04C *Add* modifier NBRSER to health service code 65.04C.

65.51 *Amend* health service code 65.51 to read:
Repair of incisional hernia
NOTE: 1. **Refer to Price List for benefit when performed in** conjunction with other abdominal procedures.
2. May not be claimed in conjunction with bowel obstruction **HSCs** 58.81A, 58.81B, or 58.81C.
3. A second call may only be claimed if a non-contiguous site requires repair.

Add modifier NBRSER.

65.9A *Add* modifier NBRSER to health service code 65.9A.

65.9B *Add* modifier NBRSER to health service code 65.9B.

66.83 *Add* note 2 to health service code 66.83 (current note becomes note 1):
2. May be claimed in addition to HSCs 55.8A, 55.8B, 55.8C, 55.8D, 55.9A, 55.99A, 55.9B, 55.9C, 64.43A, 64.49.

67.11B *Amend* health service code 67.11B to read:
Removal of renal calculus
Percutaneous, ureteroscopic or open surgery approach.
NOTE: 1. **Benefit i**ncludes cystoscopy and retrograde pyelogram and all related operative procedures for removal of stone performed during the same hospital admission.
2. **For a r**epeat percutaneous or ureteroscopic procedure during the same hospitalization, **benefit** will be **reduced.** Refer to Price List.
3. Two calls may only be claimed for bilateral removal of calculus.

Add modifier NBRSER.

68.2A *Amend* health service code 68.2A to read:
Removal of calculus from ureter
Percutaneous, ureteroscopic or open surgery approach
NOTE: 1. **Benefit i**ncludes cystoscopy and retrograde pyelogram and all related operative procedures for removal of stone performed during the same hospital admission.
2. **For a r**epeat percutaneous or ureteroscopic procedure during the same hospitalization**, benefit will be reduced.** Refer to Price List.
3. Two calls may only be claimed for bilateral removal of calculus.

Add modifier NBRSER.

74.4E *Add* a new health service code 74.4E:
Laparoscopic Orchidopexy 773.95

97.11B *Amend* number of calls (modifier NBRSER) for health service code 97.11B to read:

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

97.22A *Amend* number of calls (modifier NBRSER) for health service code 97.22A to read:

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

97.29A *Amend* number of calls (modifier NBRSER) for health service code 97.29A to read:

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

SECTION OF INFECTIOUS DISEASES

Health Service Codes

03.01NJ *Add* a new health service code 03.01NJ
Patient care advice to active treatment facility worker in relation to a patient receiving outpatient IV medication day treatment, weekdays 0700 to 1700 hours.....16.95
NOTE: Refer to the notes following HSC 03.01NL.

03.01NK *Add* a new health service code 03.01NK
Patient care advice to active treatment facility worker in relation to a patient receiving outpatient IV medication day treatment, weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours 25.03
NOTE: Refer to the notes following HSC 03.01NL.

03.01NL *Add* a new health service code 03.01NL
Patient care advice to active treatment facility worker in relation to a patient receiving outpatient IV medication day treatment, any day 2200 to 0700 hours 29.54
NOTE:
1. Active treatment facility worker may include Registered Nurse, Licensed Practical Nurse, Occupational Therapist, Physiotherapist, Speech Language Pathologist, Social Worker, Pharmacist, Psychologist, Recreational Therapist or Respiratory Therapist.
2. May only be claimed by infectious disease specialists, internal medicine and rheumatologists.
3. May only be claimed when the physician is outside the facility from where the patient is located.
4. May be claimed for advice given to the worker by telephone or other telecommunication means.
5. To be claimed using the Personal Health Number of the patient.
6. May only be claimed when the call is initiated by the health care worker.
7. A maximum of two (any combination of HSCs 03.01NJ, 03.01NK, 03.01NL) claims may be made per patient, per physician, per day.
8. Documentation of the communication must be recorded in their respective records.

SECTION OF INTERNAL MEDICINE

General Rules

GR 11.2.1 *Add* 03.38X to Level I and Level II procedures.

Health Service Codes

03.01NJ *Add* a new health service code 03.01NJ
Patient care advice to active treatment facility worker in relation to a patient receiving outpatient IV medication day treatment, weekdays 0700 to 1700 hours 16.95
NOTE: Refer to the notes following HSC 03.01NL.

03.01NK *Add* a new health service code 03.01NK
Patient care advice to active treatment facility worker in relation to a patient receiving outpatient IV medication day treatment, weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours 25.03

03.01NL *Add* a new health service code 03.01NL
Patient care advice to active treatment facility worker in relation to a patient receiving outpatient IV medication day treatment, any day 2200 to 0700 hours 29.54
NOTE:
1. Active treatment facility worker may include Registered Nurse, Licensed Practical Nurse, Occupational Therapist, Physiotherapist, Speech Language Pathologist, Social Worker, Pharmacist, Psychologist, Recreational Therapist or Respiratory Therapist.
2. May only be claimed by infectious disease specialists, internal medicine and rheumatologists.
3. May only be claimed when the physician is outside the facility from where the patient is located.
4. May be claimed for advice given to the worker by telephone or other telecommunication means.
5. To be claimed using the Personal Health Number of the patient.
6. May only be claimed when the call is initiated by the health care worker.
7. A maximum of two (any combination of HSCs 03.01NJ, 03.01NK, 03.01NL) claims may be made per patient, per physician, per day.
8. Documentation of the communication must be recorded in their respective records.

03.03AT *Add* a new health service code 03.03AT:
Patient admission at the request of an internal medicine specialist triage physician.....183.86
NOTE: 1. May only be claimed by internal medicine at the time the patient is seen.
2. May be claimed on the date of transfer by the receiving physician when admitting the patient.
3. May not be claimed in addition to any other visit or consultation on the same date of service by the same physician.
4. Callbacks and HSC 03.03DF at a separate encounter for the same date of service by the same or different physician may be claimed in addition.

03.03FA *Amend* note 2 following health service code 03.03FA to read:
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, internal medicine,** medical genetics or physiatrists (no age restriction).

03.04K *Add* a new health service code 03.04K:
Comprehensive geriatric assessment, first hour and 30 minutes.....300.00
NOTE: 1. If the assessment is less than 1 hour and 30 minutes, then HSC 03.04A or 03.08A should be claimed.
2. May only be claimed when performed in a regional facility.
3. May only be claimed for patients aged 75 years or older.
4. May only be claimed by general practitioners, internal medicine specialists or geriatric medicine specialists.
5. May be claimed in addition to HSC 03.04J.
6. May only be claimed once per patient per year.
7. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List, to a maximum of 6 calls.
8. Assessment must include the following components:
a) Medical includes but is not limited to a complete physical examination, a problem list, co morbidity conditions and disease severity, a medication review and nutritional status.
b) Functional includes but is not limited to a review of basic activities of daily living, instrumental activities of daily living, activity/ exercise status, gait and balance.
c) Cognitive/psychological includes but is not limited to review of mental status, administration of the Mini Mental State Examination (MMSE) and mood/depression testing through Geriatric Depression Scale (GDS).
d) Social includes but is not limited to a review of informal support needs and assets, care resource eligibility and a financial assessment.
e) Environmental includes but is not limited to a review of current living situation, home safety and transportation.

03.08I *Amend* health service code 03.08I to read:
Prolonged **gastroenterology, internal medicine,** physiatry or neurology consultation, per 15 minutes
NOTE: May only be claimed in addition to HSC 03.08A for consultations exceeding **30** minutes.

03.3 *Add* the following to heading 03.3:
Refer to GRs 11.2.1 and 11.2.2 for additional information pertaining to HSCs 03.37A to 03.38X inclusive.

13.99O *Amend* note 4 following health service code 13.99O to read:
4. **HSC 03.03AR , 03.03DF and s**pecial callback benefits (**HSCs** 03.05N, 03.05P, 03.05QA, 03.05QB, 03.05R) may be claimed in the same calendar week for the same patient by the same physician.

Modifiers

CALL *Add* a new modifier to CALL CALLS UNITS:
COMGER – COMPREHENSIVE GERIATRIC ASSESSMENT PER 1 1/2 HOURS + EACH ADDITIONAL 1/4 HOUR – (Implicit) – First unit represents 1 ½ hours, each subsequent unit represents 15 minutes.

SECTION OF NEPHROLOGY

Health Service Codes

13.99O *Amend* note 4 following health service code 13.99O to read:

4. **HSC 03.03AR , 03.03DF and s**pecial callback benefits (**HSCs** 03.05N, 03.05P, 03.05QA, 03.05QB, 03.05R) may be claimed in the same calendar week for the same patient by the same physician.

13.99OA *Add* a new health service code 13.99OA:

Management of patient on hemodialysis or peritoneal dialysis
(per week) 135.00

NOTE:
1. May only be claimed by nephrologists.
2. May not be claimed in addition to HSC 13.99B or 13.99D within the same calendar week.
3. May be claimed once per patient within the same calendar week if not preceded by any visit except those outlined in Note 4.
4. HSCs 03.03AR, 03.03DF and special callback benefits (HSCs 03.03KA, 03.03LA, 03.03MC, 03.03MD, 03.05N, 03.05P, 03.05QA, 03.05QB, 03.05R) may be claimed within the same calendar week for the same patient by the same physician.
5. Other HSCs (03.08A, 03.07B, 03.04A, 03.03A, 03.03F) may not be claimed in the same calendar week for the same patient by any nephrologist. Exceptions to this include consultation and visit HSCs that are related to assessment for kidney/kidney-pancreas transplantation, which may be claimed within the same calendar week by nephrologists with special interest or training in transplantation. For the exceptions, supporting text must be submitted.

SECTION OF NEUROLOGY

Health Service Codes

03.08I *Amend* health service code 03.08I to read:
Prolonged **gastroenterology, internal medicine,** physiatry or neurology consultation, per 15 minutes
NOTE: May only be claimed in addition to HSC 03.08A for consultations exceeding **30** minutes.

17.92C *Amend* health service code 17.92C:
Change category code from "M" to "1".

SECTION OF OBSTETRICS AND GYNECOLOGY

Health Service Codes

03.01LM *Add* a new health service code 03.01LM:
Patient care advice to active treatment facility worker or nurse practitioner in relation to the obstetrical outpatient, weekdays 0700 – 1700 hours.....16.95
NOTE: Refer to the notes following HSC 03.01LO.

03.01LN *Add* a new health service code 03.01LN
Patient care advice to active treatment facility worker or nurse practitioner in relation to the obstetrical outpatient, weekdays 1700 – 2200 hours, weekends and statutory holidays 0700 – 2200 hours 25.03
NOTE: Refer to the notes following HSC 03.01LO.

03.01LO *Add* a new health service code 03.01LO
Patient care advice to active treatment facility worker or nurse practitioner in relation to the obstetrical outpatient, any day 2200 – 0700 hours 29.54
NOTE:
1. Active treatment facility worker may include Registered Nurse, Licensed Practical Nurse, midwife.
2. To be claimed using the Personal Health Number of the patient.
3. May only be claimed by general practice or obstetrics and gynecology.
4. 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.
5. May only be claimed when the physician is outside the facility from where the patient is located.
6. May only be claimed when the call is initiated by the active treatment facility worker or nurse practitioner.
7. May only be claimed for advice given to the active treatment facility worker or nurse practitioner by telephone or other telecommunication means.
8. A maximum of two (any combination of HSC 03.01LM, 03.01LN or 03.01LO) may be claimed per patient, per physician, per day.
9. Documentation of the communication must be recorded in their respective records.

13.59M *Add* note 2 to health service code 13.59M:
2. May only be claimed by urology, obstetrics and gynecology.

70.4A *Add* skill restriction OBGY to health service code 70.4A.

80.19D *Add* note 2 to health service code 80.19D (current becomes note 1):
2. Benefit includes insertion of a laminaria tent if required by same or different physician.

87.29B *Add* a new health service code 87.29B:
Termination of pregnancy, dilatation and evacuation (D&E) termination where imaging report confirms fetus is 12 weeks size or greater 250.00
NOTE: May be claimed for termination of viable or non-viable pregnancy.

SECTION OF OPHTHALMOLOGY

General Rules

GRs 9.1.2 and 9.1.3

Delete 09.13A from GRs 9.1.2 and 9.1.3.

Add the following:
09.13E Optical coherence tomography, interpretation
09.13F Optical coherence tomography, technical

Health Service Codes

09.13A *Delete* health service code 09.13A.

09.13E *Add* a new health service code 09.13E:
Optical coherence tomography, interpretation.....30.00

Comment: When 09.13E is performed for hospital patients payment is the responsibility of the hospital or region.

09.13F *Add* a new health service code 09.13F:
Optical coherence tomography, technical.....35.52

Comment: When 09.13F is performed for hospital patients payment is the responsibility of the hospital or region.

21.31A *Amend* health service code 21.31A to read:
Diagnostic irrigation of nasolacrimal duct

21.31B *Add* a new health service code 21.31B:
Probing of nasolacrimal duct for patients 18 years of age and under 129.05
NOTE: May only be claimed when performed in an operating room, day surgery or non hospital surgical facility.

22.13B *Add* a note following health service code 22.13B to read:
NOTE: May be claimed in addition to a visit or consultation.

22.69A *Amend* health service code 22.69A to read:
Lid repair, full thickness without flap or graft
NOTE: Single fee applies regardless of whether the upper or lower or both eyelids of same eye are involved. If second eye needs to be done, the fee for the second eye may be claimed at 75%.

22.69B *Amend* health service code 22.69B to read:
Lid repair, full thickness with flap or graft
NOTE: Single fee applies regardless of whether the upper or lower or both eyelids of same eye are involved. If second eye needs to be done, the fee for the second eye may be claimed at 75%.

23.99D *Add* a note following health service code 23.99D:
NOTE: May be claimed in addition to a visit or consultation.

23.99E *Delete* health service code 23.99E.

Comment: Follow-up treatments can now be billed under 23.99D

26.2A *Delete* the note following health service code 26.2A. See changes to REDO modifier for ophthalmology re-operations.

26.25A *Delete* health service code 26.25A.

Comment: This can now be claimed under health service code 26.22A using modifier REOP.

SECTION OF ORTHOPEDICS

General Rules

GR 6.17.1 *Add* 16.09P, 16.49B, 16.49C, 16.49D, 16.49E, 92.31Q to GR 6.17.1.

Health Service Codes

89.07 *Delete* health service code 89.07.

89.57B *Amend* health service code 89.57B to read:
Local excision of lesion or tissue of bone, tarsals and metatarsals, sequestrectomy or saucerization

89.58C *Delete* health service code 89.58C.

90.03B *Amend* health service code 90.03B to read:
Bone graft metacarpal **or phalanx**

91.36C *Amend* health service code 91.36C to read:
ORIF of fracture, other tarsal bone**, including navicular bone**

91.36F *Delete* health service code 91.36F.

91.36H *Add* health service code 91.36H:
Talar fracture, complex.....922.67
NOTE: May only be claimed for repairs of 2 of either:
- Body fracture (s)
- Neck fracture or
- lateral process fractures.

91.71 *Add* a note to health service code 91.71:
NOTE: May not be claimed for dislocated radial head.

91.88B *Amend* health service code 91.88B to read:
Open reduction of dislocation acromio-clavicular**, acute repair, less than 6 weeks from date of injury**

Comment: The NUFRAC modifier is deleted as it no longer applies.

91.88C *Add* health service code 91.88C:
Open reduction of dislocation acromio-clavicular chronic repair, greater than 6 weeks from date of injury 377.46

93.45A *Amend* health service code 93.45A to read:
Anterior cruciate ligament reconstruction **with bone - patellar tendon graft**

Add modifier NBRSER.

93.83B *Amend* health service code 93.83B to read:
Repair recurrent sterno-clavicular, acromioclavicular dislocation **with tendon graft from different site**

93.87A *Amend* health service code 93.87A to read:
Arthroplasty **distal** radio-ulnar joint**, including resection soft tissue interposition technique or resection fusion technique**

93.87H *Delete* health service code 93.87H.

93.96L *Add* a new health service code 93.96L:
Ligament repair, elbow, acute, less than 14 days 486.99

96.01A *Amend* number of calls (modifier NBRSER) for health service code 96.01A to read:

1	For Each Call Pay Base At	100%
2-8	For Each Call Increase By	**75%**

96.01B *Add* a new health service code 96.01B:
Amputation and disarticulation of finger, through MP joint 188.00

96.02A *Add* a new health service code 96.02A:
Amputation and disarticulation of thumb 170.00

96.02B *Add* a new health service code 96.02B:
Amputation and disarticulation of thumb, through MP joint 188.00

96.03C *Delete* health service code 96.03C.

96.12B *Amend* number of calls (modifier NBRSER) for health service code 96.12BA to read:

1	For Each Call Pay Base At	100%
2-2	For Each Call Pay Base At	75%

SECTION OF OTOLARYNGOLOGY - HEAD AND NECK SURGERY

Health Service Codes

09.43 *Amend* note 1 and note 2 of health service code 09.43 to read:

1. **HSCs 09.43A through 09.43E** may be claimed by practitioners using sound-treated booths and calibrated equipment.
2. Audiometry workup to include four or more of the following **HSCs** to a maximum of $**19.33.**

40.1 *Amend* health service code 40.1 to read:
Tonsillectomy **for patient 14 years of age and over**
NOTE: May be claimed in addition to **HSC** 40.5.

40.2 *Amend* health service code 40.2 to read:
Tonsillectomy **for patient under 14 years of age**
NOTE: May be claimed in addition to HSC 40.5.

40.5 *Amend* health service code 40.5 to read:
Adenoidectomy
NOTE: May be claimed in addition to **HSC 40.1 or 40.2.**

SECTION OF PEDIATRICS

Health Service Codes

03.04F *Amend* health service code 03.04F to read:
Comprehensive visit in an emergency department, weekday, 0700-1700 hours
NOTE: Refer to the notes following HSC 03.04H.

03.04G *Amend* health service code 03.04G to read:
Comprehensive visit in an emergency department, weekday, 1700-2200 hours or on Saturday, Sunday or statutory holiday, 0700-2200 hours
NOTE: Refer to the notes following HSC 03.04H.

03.04H *Amend* health service code 03.04H to read:
Comprehensive visit in emergency department, 2200-0700 hours
NOTE: 1. **HSCs 03.04F, 03.04G, 03.04H may only be claimed by emergency medicine physicians, full time emergency room physicians, general practitioners or pediatricians working a rotation duty shift in an emergency department with 24 hour on-site coverage or by physicians who are providing first call coverage in an emergency department that has greater than 25,000 visits to the emergency room per year.**
2. **HSCs** 03.04F, 03.04G, 03.04H may be claimed for those patients whose illness/injury requires prolonged observation, continuous therapy and multiple reassessments as described in GR 4.2.7 **or for female patients requiring an internal examination because of obstetrical problems or gynecological bleeding.**

03.3 *Add* the following to heading 03.3:
Refer to GRs 11.2.1 and 11.2.2 for additional information pertaining to HSCs 03.37A to 03.38X inclusive.

50.99F *Add* health service code 50.99F:
Removal and reinsertion of long dwelling intravascular catheter requiring subcutaneous tunnel under general anesthesia.....307.31

50.99G *Add* health service code 50.99G:
Removal of long dwelling intravascular catheter requiring subcutaneous tunnel under general anesthesia.....129.05

74.4E *Add* a new health service code 74.4E:
Laparoscopic Orchidopexy.....773.95

Modifiers

CMXV15 *Amend* the last bullet following modifier CMXV15 to read:

- cardiology, **endocrinology/metabolism,** haematology, infectious diseases, internal medicine, medical oncology, nephrology, pediatric cardiology, **pediatrics** for HSCs 03.03A, 03.03F, 03.07A, 03.07B. **Pediatrics may claim for HSC 03.05JK.**

CMXV30 *Amend* the last bullet following modifier CMXV30 to read:

- cardiology, **endocrinology/metabolism,** haematology, infectious diseases, internal medicine, medical oncology, nephrology, pediatric cardiology**, pediatrics** for HSCs 03.03A, 03.03F, 03.07A, 03.07B.
Pediatrics may claim for HSC 03.05JK.

SECTION OF PHYSICAL MEDICINE AND REHABILITATION

Health Service Codes

03.05JM *Add* a new health service code 03.05JM:
Formal, scheduled, professional conference related to the care and treatment of multiple patients undergoing rehabilitation therapy including those with chronic pain with other physician(s), allied health professionals, educational, correctional and other community agencies on behalf of a specific patient, provided by the physiatrist most responsible for the patient's care.....17.18
NOTE: Refer to the notes following HSC 03.05JN.

03.05JN *Add* a new health service code 03.05JN:
Second and subsequent physician attendance at a formal, scheduled, professional conference related to the care and treatment of multiple patients undergoing rehabilitation therapy including those with chronic pain, when discussion occurs on behalf of a specific patient.....17.18
NOTE: 1. HSC 03.05JM may only be claimed by Physiatry.
2 HSC 03.05JN may be claimed by any physician that is participating in the conference.
3. HSCs 03.05JM and 03.05JN are to be claimed using the Personal Health Number of the patient.
4. Each physician involved in a patient conference may claim for patient services using HSCs 03.05JM or 03.05JN, per patient, to a maximum of 6 patients in a 30 minute period.
5. HSC 03.05JN may be claimed when the physician most responsible for the patient's care has submitted a claim under 03.05JM.

03.08I *Amend* health service code 03.08I to read:
Prolonged **gastroenterology, internal medicine,** physiatry or neurology consultation, per 15 minutes
NOTE: May only be claimed in addition to HSC 03.08A for consultations exceeding **30** minutes.

SECTION OF PLASTIC SURGERY

General Rules

GR 7.1.1 *Amend* GR 7.1.1 to read:
Functional area includes the following anatomical areas: Head, face, neck, **shoulder**, axilla, elbow, wrist, hand, groin, perineum, knee, ankle, foot, and includes coverage of exposed vital structures (bone, tendon, major vessel, nerve).
NOTE: Paired structures would be claimed as two separate areas, e.g., right and left wrist would be claimed as two separate areas.

GR 7.1.2 *Amend* GR 7.1.2 to read:
Non-functional area includes the following anatomical areas: Posterior trunk, anterior trunk, **arm (above elbow), forearm (below elbow), thigh, leg (below knee).**
NOTE: Paired structures would be claimed as two separate areas, e.g., right and left arm would be claimed as two separate areas.

GR 7.2.2b) *Amend* note b) following GR 7.2.2 to read:
b) **second and subsequent anatomical area(s) - 75% of the listed benefit.**

Health Service Codes

22.69A *Amend* health service code 22.69A to read:
Lid repair, full thickness without flap or graft
NOTE: Single fee applies regardless of whether the upper or lower or both eyelids of same eye are involved. If second eye needs to be done, the fee for the second eye may be claimed at 75%.

22.69B *Amend* health service code 22.69B to read:
Lid repair, full thickness with flap or graft
NOTE: Single fee applies regardless of whether the upper or lower or both eyelids of same eye are involved. If second eye needs to be done, the fee for the second eye may be claimed at 75%.

35.0A *Amend* the note following health service code 35.0A to read:
NOTE: May be claimed when performed by a physician on an emergency basis **or when required as part of surgical repair of fractured mandible.**

89.07 *Delete* health service code 89.07.

89.57B *Amend* health service code 89.57B to read:
Local excision of lesion or tissue of bone, tarsals and metatarsals, sequestrectomy or saucerization

94.72B *Add* health service code 94.72B:
First stage of tendon graft using alloplastic spacer 357.00

95.01A *Delete* health service code 95.01A.

96.01A *Amend* number of calls (modifier NBRSER) for health service code 96.01A to read:

1	For Each Call Pay Base At	100%
2-**8**	For Each Call Increase By	**75%**

96.01B *Add* a new health service code 96.01B:
Amputation and disarticulation of finger, through MP joint 188.00

96.02A *Add* a new health service code 96.02A:
Amputation and disarticulation of thumb 170.00

96.02B *Add* a new health service code 96.02B:
Amputation and disarticulation of thumb, through MP joint 188.00

96.03C *Delete* health service code 96.03C.

96.12B *Amend* number of calls (modifier NBRSER) for health service code 96.12BA to read:

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

97.22A *Amend* number of calls (modifier NBRSER) for health service code 97.22A to read:

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

97.29A *Amend* number of calls (modifier NBRSER) for health service code 97.29A to read:

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

98.11 *Amend* the note following heading 98.11 to read:
NOTE: Only one of **HSCs** 98.11A to 98.11F may be claimed per **functional or non-functional** anatomical area **as defined in GRs 7.1.1 and 7.1.2 with the exception of paired structures which may be claimed as two.**

98.11A *Amend* health service code 98.11A to read:
Non-functional area, up to 32 **total** square cms

98.11B *Amend* health service code 98.11B to read:
Non-functional area, over 32 and up to 64 **total** square cms

98.11C *Amend* health service code 98.11C to read:
Non-functional area, over 64 **total** square cms

98.11D *Amend* health service code 98.11D to read:
Functional area, up to 32 **total** square cms

98.11E *Amend* health service code 98.11E to read:
Functional area, over 32 and up to 64 **total** square cms

98.11F *Amend* health service code 98.11F to read:
Functional area, over 64 **total** square cms

98.12G *Add* modifier UGA to health service code 98.12G.

98.49 *Amend* health service code 98.49 to read:
Other free skin graft to other sites
Non-functional **areas** split thickness skin grafts
NOTE: 1. Refer to GRs 7.1.1 through 7.2.2.
2. Only one of HSCs 98.49A to 98.49G may be claimed per anatomical area as defined in GRs 7.1.1 and GR 7.1.2 with the exception of paired structures which may be claimed as two.

98.49A *Amend* health service code 98.49A to read:
Non-functional split thickness skin graft, up to 32 **total** square cms
NOTE: Refer to the notes following HSC 98.49D.

98.49B *Amend* health service code 98.49B to read:
Non-functional split thickness skin graft over 32 and up to 64 **total** square cms
NOTE: Refer to the notes following HSC 98.49D.

98.49C *Amend* health service code 98.49C to read:
Non-functional split thickness skin graft over 64 and up to 100 **total** square cms
NOTE: Refer to the notes following HSC 98.49D.

98.49D *Amend* health service code 98.49D to read:
Non-functional split thickness skin graft over 100 **total** square cms
NOTE: **1. For grafts over 100 square cms, only one HSC 98.49D may be claimed per anatomical area.**
2. Refer to GRs 7.1.1 through 7.2.2 for explanation of functional and non-functional areas.
3. Only one of HSCs 98.49A, 98.49B, 98.49C or 98.49D may be claimed per anatomical area unless it is for a paired structure.
4. If several grafts of less than 100 sq cms are performed in the same anatomical area, the maximum that may be claimed is one HSC 98.49D.

98.49E *Amend* health service code 98.49E to read:
Functional split thickness skin graft up to 32 **total** square cms

98.49F *Amend* health service code 98.49F to read:
Functional split thickness skin graft over 32 and up to 64 **total** square cms

98.49G *Amend* health service code 98.49G to read:
Functional split thickness skin graft over 64 **total** square cms

98.49H *Delete* health service code 98.49H.

98.49J *Delete* health service code 98.49J.

98.49K *Delete* health service code 98.49K.

98.49N *Add* a new health service code 98.49N:
Functional split thickness skin graft over 100 total square cms 695.00

98.5 *Delete* note 7 from heading 98.5.

98.51A *Delete* note 1 following health service code 98.51A. *Renumber* notes 2 and 3.

SECTION OF RESPIRATORY MEDICINE

General Rules

GR 11.2.1 *Add* 03.38X to Level I and Level II procedures.

Health Service Codes

03.3 *Add* the following to heading 03.3:
Refer to GRs 11.2.1 and 11.2.2 for additional information pertaining to HSCs 03.37A to 03.38X inclusive.

03.38X *Add* a new health service code 03.38X:
Asthma exercise test utilizing treadmill or bicycle ergometer 115.00
NOTE: 1. Benefit includes the technical, interpretation and continuous, personal physician monitoring components of the procedure.
2. Benefit includes monitoring heart rate, oximetry and flow volume loops.

SECTION OF RHEUMATOLOGY

Health Service Codes

03.01NJ *Add* a new health service code 03.01NJ
Patient care advice to active treatment facility worker in relation to a patient receiving outpatient IV medication day treatment, weekdays 0700 to 1700 hours 16.95
NOTE: Refer to the notes following HSC 03.01NL.

03.01NK *Add* a new health service code 03.01NK
Patient care advice to active treatment facility worker in relation to a patient receiving outpatient IV medication day treatment, weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours 25.03
NOTE: Refer to the notes following HSC 03.01NL.

03.01NL *Add* a new health service code 03.01NL
Patient care advice to active treatment facility worker in relation to a patient receiving outpatient IV medication day treatment, any day 2200 to 0700 hours 29.54
NOTE:
1. Active treatment facility worker may include Registered Nurse, Licensed Practical Nurse, Occupational Therapist, Physiotherapist, Speech Language Pathologist, Social Worker, Pharmacist, Psychologist, Recreational Therapist or Respiratory Therapist.
2. May only be claimed by infectious disease specialists, internal medicine and rheumatologists.
3. May only be claimed when the physician is outside the facility from where the patient is located.
4. May be claimed for advice given to the worker by telephone or other telecommunication means.
5. To be claimed using the Personal Health Number of the patient.
6. May only be claimed when the call is initiated by the health care worker.
7. A maximum of two (any combination of HSCs 03.01NJ, 03.01NK, 03.01NL) claims may be made per patient, per physician, per day.
8. Documentation of the communication must be recorded in their respective records.

SECTION OF THORACIC SURGERY

General Rules

GR 6.15.4 *Add* 49.7JA, 49.7KA, 49.7LA, 49.7MA to GR 6.15.4.

Health Service Codes

49.7JA *Add* a new health service code 49.7JA:
Single chamber (right ventricular) implantable cardioverter defibrillator, insertion and testing 1050.00
NOTE: 1. May only be claimed by cardiologists or thoracic surgeons.
2. May not be claimed in addition to electrophysiology studies (HSCs 49.98F through 49.98Y).

49.7KA *Add* a new health service code 49.7KA:
Dual chamber implantable cardioverter defibrillator insertion and testing 1310.00
NOTE: 1. May only be claimed by cardiologists or thoracic surgeons.
2. May not be claimed in addition to electrophysiology studies (HSCs 49.98F through 49.98Y).

49.7LA *Add* a new health service code 49.7LA:
Cardiac resynchronization defibrillator insertion without arterial lead and testing.....1750.00
NOTE: 1. May only be claimed by cardiologists or thoracic surgeons.
2. May not be claimed in addition to electrophysiology studies (HSCs 49.98F through 49.98Y).

49.7MA *Add* a new health service code 49.7MA:
Cardiac resynchronization defibrillator insertion and testing.....2012.00
NOTE: 1. May only be claimed by cardiologists or thoracic surgeons.
2. May not be claimed in addition to electrophysiology studies (HSCs 49.98F through 49.98Y).

49.7N *Add* a new health service code 49.7N:
Percutaneous venoplasty for lead placement.....600.00
NOTE: 1. May only be claimed by cardiologists or thoracic surgeons.
2. May be claimed in addition to HSCs 49.7 A, 49.7 F, 49.7 G, 49.7 H, 49.7JA, 49.7KA, 49.7LA and 49.7MA.

55.8A *Add* a note to health service code 55.8A:
NOTE: May be claimed in addition to HSC 66.83.

SECTION OF UROLOGY

Health Service Codes

13.59M *Add* note 2 to health service code 13.59M:
2. May only be claimed by urology, obstetrics and gynecology.

67.11B *Amend* health service code 67.11B to read:
Removal of renal calculus
Percutaneous, ureteroscopic or open surgery approach.
NOTE: 1. **Benefit i**ncludes cystoscopy and retrograde pyelogram and all related operative procedures for removal of stone performed during the same hospital admission.
2. **For a r**epeat percutaneous or ureteroscopic procedure during the same hospitalization, **benefit** will be **reduced.** Refer to Price List.
3. Two calls may only be claimed for bilateral removal of calculus.

Add modifier NBRSER.

68.2A *Amend* health service code 68.2A to read:
Removal of calculus from ureter
Percutaneous, ureteroscopic or open surgery approach
NOTE: 1. **Benefit i**ncludes cystoscopy and retrograde pyelogram and all related operative procedures for removal of stone performed during the same hospital admission.
2. **For a r**epeat percutaneous or ureteroscopic procedure during the same hospitalization**, benefit will be reduced.** Refer to Price List.
3. Two calls may only be claimed for bilateral removal of calculus.

Add modifier NBRSER.

70.4B *Delete* health service code 70.4B.

70.4C *Delete* health service code 70.4C.

70.4D *Delete* health service code 70.4D.

70.4E *Delete* health service code 70.4E.

70.4H *Add* a new health service code 70.4H:
Anastomotic stricture repair 812.65

70.4I *Add* a new health service code 70.4I:
One stage reconstruction of anterior urethra with tissue transfer 1393.11

70.4J *Add* a new health service code 70.4J:
Posterior reconstruction (urethral distraction defect after pelvic fracture).....1277.02

70.4K *Add* a new health service code 70.4K:
First stage urethral reconstruction (complex structures with fibrosis, fistulae or significant loss of urethra).....1160.93

70.4L *Add* a new health service code 70.4L:
Second stage urethral reconstruction (may only claimed after first stage reconstruction).....1160.93

74.4E *Add* a new health service code 74.4E:
Laparoscopic Orchidopexy.....773.95

SECTION OF VASCULAR SURGERY

Health Service Codes

96.12B *Amend* number of calls (modifier NBRSER) for health service code 96.12BA to read:

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