Alberta Government

Bulletin

Alberta Health Care Insurance Plan

Number: Med 188	**Date: December 19, 2016**	**Page:** 1 of 1
Subject: Schedule of Medical Benefits amendments January 1, 2017	**Reference:** Schedule of Medical Benefits	

To: all physicians and billing staff

Under the Amending Alberta Medical Association Agreement, the joint Schedule of Medical Benefits (SOMB) Working Group which consists of members from the Alberta Medical Association, Alberta Health Services and the Ministry of Health is required to create a list of savings initiatives.

The SOMB Working Group has produced a jointly supported list of 24 savings initiatives for implementation into the SOMB effective January 1, 2017. This bulletin outlines the changes to the SOMB resulting from these initial savings initiatives.

A second list of initiatives is expected to be implemented on April 1, 2017.

Please refer to the Bulletin Attachments A, B and C for details. Amended text is shown in bold print and underlined in the attachments.

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

The January 1, 2017 Schedule has been posted online at www.health.alberta.ca/professionals/fees.html.

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

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Attachment A
New and Amended General Rules

New General Rules

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

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

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

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

Amended General Rules

■ GR 4.6.1 Comprehensive visits and/or comprehensive/major consultations may only be claimed once every **365** days per patient by the same physician. Comprehensive visit and consultation services are defined as HSCs 03.04A, 03.08**A, 03.08B, 03.08C, 03.08F, 03.08H,03.08K,** 08.11A, 08.11C, 08.19A and 08.19AA.

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

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

■ GR 18.1 The Body Mass Index (BMI) modifier may be claimed for selected procedures, obstetrical services, anesthesia, second qualified surgeon and surgical assistant services provided in any location when the following criteria are met:

a) An adult patient has a body mass index of **40** or more.

b) A patient under 18 years of age who is above the 97th percentile for BMI on an approved pediatric growth curve.

c) The following HSCs are only eligible for the BMI modifier when the service is provided under general, spinal, epidural anesthetic or regional nerve block performed in an operating room, day surgery or surgical suite:
98.11A, 98.11B, 98.11C, 98.11D, 98.11E, 98.11F, 98.22A, 98.22B.

Attachment B
New, amended and deleted Health Service Codes

New Health Service Codes

■ 03.03ME Special call to closed office, weekdays (0000-2400)

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

■ 03.03MF Special call to closed office, weekends and statutory holidays (0000-2400)

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

■ 13.99BA Periodic Papanicolaou Smear for patients between the ages of 21 and 69

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

■ 13.99BE Pelvic examination using a speculum requiring swab(s) and/or sample(s) collection

NOTE: 1. May be claimed with a visit or consultation.
2. May not be claimed at the same encounter as HSC 13.99BA or 13.99BD.

Amended Health Service Codes (con't)

Amended Health Service Codes

03.04B	03.04J	03.04M	03.07A	03.08A	08.11A	08.11C
08.19A	08.19AA	08.19B	08.19BB	08.19C	08.19CC	08.19GA
08.19GB	13.59H	13.99BD	17.32A	17.33	17.39B	17.39C
17.71A	52.31A	52.31B	52.31C	52.31D	92.40	92.41
92.42	92.44	92.45	92.46	93.41A	93.59A	93.69B
93.69C	93.81A	93.81B	93.87C	93.96D	93.96E	98.22A
98.22B	98.51E	98.51F	X 43	X 47	X 51	X 52
X 53	X 54	X 54A	X 54B	X 55	X 56	X 57
X 57A	X 58	X 58D	X 58E	X 59	X 60	X 61
X 62	X 63	X 64	X 65	X128	X308	X309
X310	X311	X334	X335	X337	X337	

■ **03.04B –** Amend description and notes to read as follows:

03.04B Initial **prenatal** visit requiring complete history and physical examination

NOTE: 1. May not be charged within 90 days of another comprehensive visit or consultation.

2. May **only** be claimed once per pregnancy.

3. Includes a full history, examination, initiation of the prenatal record and advice to the patient.

Amended Health Service Codes (con't)

■ **03.04J** – Add Note 1 and amend Note 6 to read as follows:

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

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

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

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

■ **03.04M** – Add note to read as follows:

03.04M Pre-operative history and physical examination in relation to an insured service

NOTE: **3. May not be claimed in addition to a surgical assist (SA, SAQS, SSOS) for the same patient by the same physician.**

■ **03.07A –** Add a note to read as follows:

03.07A Minor consultation

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

■ **03.08A –** Add a note to read as follows:

03.08A Comprehensive consultation

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

Amended Health Service Codes (con't)

■ **08.11A** – Add a note to read as follows:

08.11A Requiring complete mental status examination and investigation, first full 45 minutes or major portion thereof for the first call when only one call is claimed

NOTE**: 3. HSCs 08.19GA or 08.19GB may not be claimed at the same encounter. The total time spent providing the non- referred first visit must be claimed using the applicable non-referred first visit code.**

■ **08.11C** – Add a note to read as follows:

08.11C For complex patient, requiring complete mental status examination and investigation, first full 45 minutes or major portion thereof for the first call when only one call is claimed

NOTE: **5. HSCs 08.19GA or 08.19GB may not be claimed at the same encounter. The total time spent providing the non-referred first visit must be claimed using the applicable non-referred first visit code.**

■ **08.19A** – Add a note to read as follows:

08.19A Formal major psychiatric consultation, first full 30 minutes or major portion thereof for the first call when only one call is claimed

NOTE: **2. HSCs 08.19GA or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.**

■ **08.19AA** – Add a note to read as follows:

08.19AA Formal major psychiatric consultation for a patient referred by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist, first full 30 minutes or major portion thereof for the first call when only one call is claimed

NOTE: **3. HSCs 08.19GA or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.**

■ **08.19B** – Add a note to read as follows:

08.19B Minor psychiatric consultation, full 15 minutes or major portion thereof for the first call when only one call is claimed

NOTE: HSCs 08.19GA or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.

Amended Health Service Codes (con't)

■ **08.19BB** – Add a note to read as follows:

08.19BB Minor psychiatric consultation for a patient referred by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist, full 15 minutes or major portion thereof for the first call when only one call is claimed

NOTE: **2. HSCs 08.19GA or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.**

■ **08.19C** – Add a note to read as follows:

08.19C Repeat psychiatric consultation, per full 30 minutes or major Portion thereof for the first call when only one call is claimed

NOTE: HSCs 08.19GA or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.

■ **08.19CC** – Add a note to read as follows:

08.19CC Repeat psychiatric consultation for a patient referred by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist, full 15 minutes or major portion thereof for the first call when only one call is claimed

NOTE: **2. HSCs 08.19GA or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code**.

■ **08.19GA** – Add a note to read as follows:

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

NOTE: **3. May not be claimed at the same encounter as HSCs 08.11A, 08.11C, 08.19A, 08.19AA, 08.19B, 08.19BB, 08.19C or 08.19CC.**

■ **08.19GB** – Add a note to read as follows:

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 a portion thereof

NOTE: **4. May not be claimed at the same encounter as HSCs 08.11A, 08.11C, 08.19A, 08.19AA, 08.19B, 08.19BB, 08.19C or 08.19CC.**

Amended Health Service Codes (con't)

■ **13.59H** - Amend note to read as follows:

13.59H Local infiltration of tissue

NOTE: May not be claimed with **any other procedure at the same encounter by the same or different physician.**

■ **13.99BD –** Amend notes to read as follows:

13.99BD Anal Papanicolaou Smear

NOTE: 1. Two Anal Papanicolaou smears may be claimed per patient, per physician, per year (April 1 of one year to March 31 of the following year). Additional claims may be submitted with supporting information.

2. May be claimed **in addition to** a visit or consultation.
3. May not be claimed at the same encounter as HSC **13.99BA or 13.99BE.**

■ **17.32A** – Add a note to read as follows:

17.32A Facial nerve decompression

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

■ **17.33 –** Add note to read as follows:

17.33 Release of carpal tunnel

NOTE: May not be claimed in addition to HSC 17.39C.

■ **17.39B –** Add notes to read as follows:

17.39B Major nerve exploration

NOTE: 1. May not be claimed for the release of carpal tunnel (HSC 17.33) or procedures/diagnostic conditions related to carpal tunnel.

2. May not be claimed in addition to HSC 17.39C.

■ **17.39C -** Amend note to read as follows:

17.39C Release ulnar nerve (includes transposition)

NOTE: May not be claimed with **HSCs** 17.5 A, **17.33 or 17.39B**.

■ **17.71A -** Amend note to read as follows:

17.71A Local block(s) of somatic nerve(s)

NOTE: May not be claimed with **any other procedure at the same encounter by the same or different physician.**

Amended Health Service Codes (con't)

■ **52.31A –** Add a note to read as follows:

52.31A Limited neck dissection (suprahyoid)

NOTE: HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician.

■ **52.31B –** Add a note to read as follows:

52.31B Modified neck dissection with preservation of either one or two of the non-lymphatic structures, (e.g., sternocleidomastoid muscle, jugular vein or spinal accessory nerve), unilateral including removal of all neck lymph nodes

NOTE: 1. May not be claimed with **HSCs** 17.08G, 50.72C, 95.14E.

2. HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician.

■ **52.31C –** Add a note to read as follows:

52.31C Functional or selective neck dissection with preservation of all non-lymphatic structures, (e.g., sternocleidomastoid muscle, jugular vein, spinal accessory nerve), unilateral, including removal of three or more nodal levels in the neck

NOTE: **1.** May not be claimed with **HSCs** 17.08G, 50.72C, 95.14E.

2. HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician.

■ **52.31D –** Add a note to read as follows:

52.31D Extended neck dissection

Removal of all neck lymph nodes and some non-lymphatic structures other than spinal accessory nerve, sternocleidomastoid muscle, or jugular vein. These structures may include the scalene muscle, deep neck muscles, hypoglossal nerve, carotid artery extensive resection of skin, etc, all related to or required because of tumor invasion of those structures

NOTE: **1.** May not be claimed with **HSCs** 17.08G, 50.72A, 50.72C, 95.14C, 95.14E.

2. HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician.

■ **92.40 –** Add a note to read as follows:

92.40 Synovectomy, shoulder

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

■ **92.41 –** Add a note to read as follows:

92.41 Synovectomy, elbow

NOTE: May not be claimed in addition to HSCs 93.96D or 93.96E.

Amended Health Service Codes (con't)

■ **92.42 –** Add a note to read as follows:
92.42 Synovectomy, wrist
NOTE: May not be claimed in addition to HSCs 93.87C, 93.96D or 93.96E.

■ **92.44 –** Add a note to read as follows:
92.44 Synovectomy, hip
NOTE: May not be claimed in addition to HSCs 93.59A, 93.69B, 93.69C or 93.96E.

■ **92.45 –** Add a note to read as follows:
92.45 Synovectomy, knee
NOTE: May not be claimed in addition to HSCs 93.41A or 93.96E.

■ **92.46 –** Add a note to read as follows:
92.46 Synovectomy, ankle
NOTE: May not be claimed in addition to HSCs 93.96D or 93.96E.

■ **93.41A –** Add a note to read as follows:
93.41A Total knee arthroplasty, including hemiarthroplasty
NOTE: May not be claimed in addition to HSC 92.45.

■ **93.59A –** Add a note to read as follows:
93.59A Total hip arthroplasty
NOTE: May not be claimed in addition to HSC 92.44.

■ **93.69B –** Add a note to read as follows:
93.69B Hemiarthroplasty hip with uncemented prosthesis
NOTE: May not be claimed in addition to HSC 92.44.

■ **93.69C –** Add a note to read as follows:
93.69C Hemiarthroplasty hip with cemented prosthesis
NOTE: May not be claimed in addition to HSC 92.44.

■ **93.81A –** Add a note to read as follows:
93.81A Total joint arthroplasty of shoulder (glenoid and humeral replacement)
NOTE: May not be claimed in addition to HSC 92.40.

■ **93.81B –** Amend note to read as follows:
93.81B Hemiarthroplasty of shoulder with synthetic prosthesis
NOTE: May not be claimed with **HSCs 92.40,** 93.83D, 95.65B, 93.83H or 91.30H.

Amended Health Service Codes (con't)

■ **93.87C –** Add a note to read as follows:
93.87C Total arthroplasty of wrist using synthetic prosthesis
NOTE: May not be claimed in addition to HSC 92.42.

■ **93.96D –** Add a note to read as follows:
93.96D Primary total joint arthroplasty (ankle, elbow, wrist)
NOTE: May not be claimed in addition to HSCs 92.41, 92.42 or 92.46.

■ **93.96E –** Add a note to read as follows:
93.96E Primary total joint arthroplasty with major reconstruction including structural allograft, protrusion ring/custom implant (hip, knee, ankle, shoulder, elbow, wrist)
NOTE: May not be claimed in addition to HSCs 92.40, 92.41, 92.42, 92.44, 92.45 or 92.46.

■ **98.22A –** Amend note to read as follows:
98.22A Laceration, face, up to 2.5 cms (1 unit) or body, up to 5 cms (1 unit)
NOTE: See 98.22B **for further notes and** for lacerations exceeding the lengths listed above.

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

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

Amended Health Service Codes (con't)

■ **98.51F –** Amend description and add notes to read as follows:

98.51F Free flaps involving microsurgical technique and neuro-vascular hook-up, **for procedures not related to head and neck reconstruction,** full 60 minutes or major portion thereof for the first call when only one call is claimed

NOTE: 1. May not be claimed in addition to HSCs 52.31A, 52.31B, 52.31C or 52.31D by the same or different physician at the same encounter.

2. The total time claimed for HSC 98.51F may only reflect the time spent providing micro surgery and may not include time spent providing other services.

■ **X 43 –** Add a note to read as follows:

X 43 Knee

NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

■ **X 47 –** Add a note to read as follows:

X 47 Hip

NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

■ **X 51 –** Add a note to read as follows:

X 51 Pelvis

NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

■ **X 52 –** Add a note to read as follows:

X 52 Pelvis and one hip

NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

■ **X 53 –** Add a note to read as follows:

X 53 Pelvis and both hips

NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

■ **X 54 –** Add a note to read as follows:

X 54 Sacro-iliac joints

NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

■ **X 54A –** Add a note to read as follows:

X 54A - unilateral

NOTE: Refer to the note following HSC X 54B.

Amended Health Service Codes (con't)

■ **X 54B –** Add a note to read as follows:
X 54B – bilateral

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

■ **X 55 –** Add a note to read as follows:
X 55 One area

NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

■ **X 56 –** Add a note to read as follows:
X 56 One area – with obliques

NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

■ **X 57 –** Add a note to read as follows:
X 57 Two areas

NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

■ **X 57A –** Add a note to read as follows:
X 57A Two areas (of the spine) with obliques of each area

NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

■ **X 58 –** Add a note to read as follows:
X 58 Complete spine

NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

■ **X 58D –** Amend description and notes to read as follows:
X 58D – **flexion, extension and lateral bending**

NOTE: **1. HSCs X 58A, X 58B and X 58D may not be claimed in addition to HSCs X 54A and X 54B.**

2. HSCs X58A, X58B and X58D may be claimed in addition to **HSCs** X55, X56, X57, X57A, X58 and X58E.

■ **X 58E –** Add a note to read as follows:
X 58E More than two areas (of the spine) with obliques of each area

NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

■ **X 59 –** Add a note to read as follows:
X 59 Lumbo sacral spine and pelvis

NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

Amended Health Service Codes (con't)

■ **X 60 –** Add a note to read as follows:
X 60 Lumbo sacral spine and sacro-iliac joints
NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

■ **X 61 –** Add a note to read as follows:
X 61 Lumbo sacral spine and pelvis and sacro-iliac joints
NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

■ **X 62 –** Add a note to read as follows:
X 62 Lumbo sacral spine and one hip
NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

■ **X 63 –** Add a note to read as follows:
X 63 Lumbo sacral spine and both hips
NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

■ **X 64 –** Add a note to read as follows:
X 64 Lumbo sacral spine, pelvis and one hip
NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

■ **X 65 –** Add a note to read as follows:
X 65 Lumbo sacral spine, pelvis and both hips
NOTE: May not be claimed in addition to HSCs X 54A and X 54B.

■ **X 128 –** Add notes to read as follows:
X128 Bone mineral content determination dual photon absorptiometry with or without vertebral fracture assessment (VFA)
NOTE: 1. May only be claimed once every two years from the date of the last service.
2. For patients that are at high risk or have conditions that require more frequent assessments, text describing the circumstances will be required.

■ **X 308 –** Amend description and add a note to read as follows:
X308 Ultrasound, breast**, including axilla**
NOTE: **1.** Two calls may only be claimed for bilateral ultrasound.
2. May not be claimed with HSC X309.

■ **X 309 –** Add a note to read as follows:
X309 Ultrasound, axilla
NOTE: **1.** Two calls may only be claimed for bilateral ultrasound.
2. May not be claimed with HSC X308.

Amended Health Service Codes (con't)

■ **X 310 –** Amend note to read as follows:
X310 Ultrasound, abdominal, complete or at least two abdominal organs
NOTE: May not be claimed in addition to HSC**s X311 and** X312.

■ **X 311 –** Amend note to read as follows:
X311 Ultrasound, kidneys, ureters and bladder
NOTE: 1. Benefit includes any pre-void, post-void and/or jets.
2. May not be claimed in addition to HSCs **X310,** X316 and X328.

■ **X 334 –** Amend notes to read as follows:
X334 Ultrasound, other than shoulder including joints, tendons, ligaments, muscles, single anatomic site
NOTE: **1.** A maximum of two anatomical areas may be claimed per patient, per physician, per day.
2. May not be claimed in addition to HSC X337.

■ **X 335 –** Amend notes to read as follows:
X335 Ultrasound shoulder, dedicated rotator cuff and bicep
NOTE: **1.** Two calls may only be claimed for bilateral ultrasound.
2. May not be claimed in addition to HSC X337.

■ **X 337 –** Amend notes to read as follows:
X337 Doppler, quantitative spectral analysis with directional flow and/or Doppler measurements (e.g. renal artery, portal venous system, resistivity index, etc.), additional benefit
NOTE: May not be billed in addition to HSCs X304, X306, X323, X330, X331, X332**,** X333**, X334 and X335** when services are provided by the same or different physician in the same facility on the same day.

Deleted Health Service Codes

(and their replacements)

03.05S – see HSCs 03.03ME and 03.03MF

13.99BC – see HSCs 13.99BA and 13.99BE

Attachment C

Amended Modifier Definition

■ **BMI BMI** – (Explicit) – This modifier is used to support the additional payment of 25% for selected procedures, obstetrical services, anesthesia, second qualified surgeon and surgical assistant services for adult patients **who meet requirements indicated in the Governing Rules** and patients under 18 years of age who are above the 97th percentile for BMI on an approved pediatric growth curve.