April 2015

Please share this document with your billing staff

Please ensure that your billing software has been updated to reflect the changes that are described within this document. The Billing Corner is a summary document; there are changes to rates that are not stated in the Billing Corner. Please refer to the Schedule of Medical Benefits for complete details.

Electronic copy: www.albertadocs.org/services/physicians/compensation-billing/billing-help

Disclaimer: While care has been taken to provide accurate information, the Alberta Medical Association does not warrant or guarantee the accuracy of the information contained herein. Please refer to the Schedule of Medical Benefits for complete details. If you provide services specific to more than one section, the AMA recommends that you refer to all those that are applicable to the services that you provide.

Alberta Health Care Insurance Plan
Schedule of Medical Benefits
Changes for April 1, 2015

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HIGHLIGHTS

The changes noted below will affect ALL physicians, please read carefully and share with your staff. These changes will become effective April 1, 2015.

CHANGES TO BMI MODIFIER:
The BMI modifier has changed from its previous BMISRG to the new BMIPRO.

- The New BMIPRO modifier is used in place of the BMISRG and it is billable when the patient has met the criteria for BMI.
- BMIPRO may only be claimed for procedures that have BMIPRO listed in the Price List of the Schedule of Medical Benefits. [www.health.alberta.ca/professionals/SOMB.html](http://www.health.alberta.ca/professionals/SOMB.html)
- BMIPRO is billable for listed procedures in ANY location including the physician’s office.
- Procedures that were previously listed as having BMISRG may still be submitted for additional payment using the BMIPRO modifier.
- Only one code was added to the list of eligible services: 13.99BC the new code for pap smear and/or pelvic swab.
- Claims for appropriate BMI services for dates of service April 1, 2015 and after MUST be submitted with BMIPRO.
- Claims for services that were provided before April 1, 2015 MUST be submitted using BMISRG under the previous criteria.
- This change only affects claims for the procedure and surgical assists; there are no changes to modifiers or submissions for anesthetic services.

FAQ’s
Q – What is BMI?
BMI for an adult patient, BMI is defined as a patient that has a BMI of 35 or greater at the time of the service. A pediatric patient under 18 years of age who is above the 97th percentile for BMI on an approved pediatric growth curve is considered eligible for a BMI modifier at the time of the service.

Q – Do all services have BMI modifiers?
No, select procedures such as ophthalmology and otolaryngology procedures, injections etc. do not have a BMI modifier listed. Please consult the Price List to determine if the service you perform has a BMI modifier.
[www.health.alberta.ca/professionals/SOMB.html](http://www.health.alberta.ca/professionals/SOMB.html)
The NEW BMI modifier will appear as follows in the SOMB:

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

a) An adult patient has a body mass index of 35 or more.

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

The following HSCs are only eligible for the BMI modifier when the service is provided under general, spinal, epidural anaesthetic 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

PHONE CALLS DIRECTLY TO PATIENTS:

03.05JR Physician telephone call directly to patient, to discuss patient management/diagnostic test results $15.12

NOTE: 1. A maximum of 7 telephone calls per physician, per calendar week may be claimed.

2. May not be claimed for management of patient’s anticoagulant therapy (billable under HSC 03.01N).

3. May not be claimed when communication is with a proxy for the physician.

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

FAQs:

Q – Can I bill this code when my nurse or a staff member calls the patient?

This code may only be claimed when the physician speaks directly to the patient. The phone call must be in relation to patient management or results for insured services.

Q – Why can only 7 phone calls be billed per week?

The reason the fee is set as it is and the limitation of only seven per physician per week is due to the estimated costs associated with introducing a service that is expected to be quite popular.

Q- Can I bill this service if I text or email my patient?

This service is only billable when it is performed via telephone. Services that are provided by text and email are not eligible for payment.

Q – Can I call my patient while I am away from the office or do I have to be in the office to call the patients?

A physician may submit a claim for this service from any location where a reasonably private conversation can be had with the patient. The location of the physician at the time of the call is what should be recorded on the claim. For services that occur outside of the office, use location code OTHR on the claim. It is important that documentation of the call be recorded in the patient’s record.
Q – Can I call patients while they are in the hospital?
No, this service is intended to cover communication with community patients.

NEW FAMILY CONFERENCE CODES VIA TELEPHONE:

03.05JP  Family conference via telephone relating to acute care facility in-patient or registered emergency or out-patient, or auxiliary hospital, nursing home patient, AACC or UCC patient  $40.11

NOTE: 1. Intended specifically for patients whose condition warrants periodic family conferences or for patients who are unable to properly communicate with their physician (e.g., situations where there is a language barrier, unconscious patient, etc.).
2. This service is to be claimed using the Personal Health Number of the patient.
3. May be claimed in situations where:
   a) location or mobility factors of family members at the time of the call preclude in person meetings.
   b) timely communication with family members is essential to patient care or organ/tissue transfer collection, and
   c) communication about a patient’s condition or to gather collateral information that is relative to patient management and care activities.
4. May not be claimed for:
   a) relaying results for lab or diagnostics.
   b) arranging follow up care.
5. Documentation of the communication to be maintained in the patient record.

FAQ's

Q – Can I submit a claim for a telephone family conference if I need to have regular update meetings with the family?
If the patient’s condition is such that periodic family conferences are required, this service may be claimed if the location or mobility factors of the family member(s) at the time of the call prevents an in-person meeting.

Q – Can I use this code for community patients?
No, this service is intended to cover communication with family members of patients that are registered hospital in- or out-patients, AACC/UCC, auxiliary or nursing home patients.

Q – How do I submit a claim for services in relation to organ or tissue donation?
Claims are to be submitted using the PHN of the patient. In order to receive payment for the service, it must occur on the last living date of the patient. A patient’s PHN is no longer active following the pronouncement of death. Services provided following death may no longer be submitted for payment.

Q- How do I submit a claim for talking to the patients’ family about follow up care?
Telephone family conferences may not be claimed for arranging follow up care, relaying information about results (to be billed using new code 03.05JR see notes) or INR management (to be billed using 03.01N).
Q – What location code do I use on the claim?
For all phone call codes, the location of the physician at the time of the call is to be used on the claim.

Q – Can I bill other visit codes in addition to the family conference codes at the same encounter or on the same date?
Yes, other services provided to the patient on the same date of service or at the same encounter may be submitted for payment.

03.05JQ  Family conference with relative(s) via telephone in connection with the management of a patient with a psychiatric disorder  $50.66
NOTE: 1. This service is to be claimed using the Personal Health Number of the patient.
2. May be claimed in situations where:
   a) the patient’s family is to be notified of a mental health crisis.
   b) location or mobility factors of family members at the time of the call preclude in person meetings.
   c) timely communication with family members is essential to patient care and/or management.
   d) communication about a patient’s condition is required to gather collateral information that is relative to the patient management and care activities.
3. May not be claimed for:
   a) relaying results for lab or diagnostics.
   b) gathering information that is in relation to the development of a Community Treatment Order (CTO).
   c) arranging for follow-up care.
4. Documentation of the communication and relationship of family member to the patient must be recorded in the patient record.

FAQ’s
Q – Can I submit a claim for a telephone family conference if I need to have regular update meetings with the family?
No, this service is meant to cover services that are provided in a time of crisis. This code is intended for those instances where immediate or urgent information must be gathered or exchanged with family members about a patient that is suffering from a mental health crisis or situation. It may also be used in those situations where patient management or treatment options must be discussed with family members and location or mobility factors of family members at the time of the call prevent an in-person meeting.

Q – Can I use this code for community patients and hospital patients?
Yes, this service is intended to cover communication with family members of patients that are presenting with a mental health crisis regardless of location.

Q – What if I need to talk to the family about the patient’s CTO or test results?
Claims for discussion about test results may be claimed using the new code 03.05JR as appropriate, CTO development or in relation to CTO – may be claimed as 08.19L/M/N as appropriate.
Q – What location code do I use on the claim?
For all phone call codes, the location of the physician at the time of the call is to be used on the claim.

Q – Can the patient be present during the phone call?
Claims may be paid for the service regardless of whether the patient is present or not. Documentation of the service must be made in the patient’s record.

Q – Can I bill other visit codes in addition to the family conference codes at the same encounter or on the same date?
Yes, other services provided to the patient on the same date of service or at the same encounter may be submitted for payment.

**CORNEAL CROSSLINKING (CXL)**

Alberta Health has completed a review of the corneal cross-linking (CXL) for the treatment of corneal thinning disorders, including keratoconus. Based on the results of the provincial review and recommendations from the Alberta Advisory Committee on Health Technologies (AACHT) Alberta Health has made the decision to fund CXL epithelium off procedure for select patient population.

In order to be eligible for the procedure, patients must have a greater than 1 Dioptre change in refractive astigmatism and a greater than one line loss of corrected acuity documented over a minimum of three examinations (one baseline and two follow ups). In addition, CXL may not be claimed for services provided in association or relation to refractive surgery EITHER 2 YEARS PRECEDING REFRACTIVE SURGERY OR 2 YEARS FOLLOWING REFRACTIVE SURGERY.

Alberta Health (AH) will be introducing CXL procedure as an insured service into the Schedule of Medical Benefits (SOMB) at a later date. In the meantime, any ophthalmologist performing this service, may bill for CXL epithelium off procedure under HSC 99.09C. Alberta Health will pay **entire** CXL procedure submitted under 99.09C.

**This service can be performed in a physician’s office and there is NO requirement to have a contract for the NHSF.**

Please submit all services for CXL to **Alberta Health** under fee code 99.09C (both professional and technical components in one claim).

Audiologists were added to the list of providers that may refer patients for physician services. Audiologists that have registered with Alberta Health will have a PRACID. Audiologists will be included in the following GRs: 4.3.1, 4.3.2, 4.4.1, 4.4.2, 4.4.3, 4.4.5, 4.4.6, 4.5.2, 4.8.4

TELE HEALTH - (Explicit) - This modifier is used to indicate telehealth services.

TELE HEALTH - (Explicit) - A Medical consultant (other than a radiologist) may claim the appropriate consultation health service code with modifier TELES when a patient is referred from another physician, audiologist, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner. Referrals from a non-physician other than an audiologist, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner may be claimed under the appropriate non-referred visit health service code.

A Podiatric Surgeon consultant may claim the appropriate consultation health service code with modifier TELES when a patient is referred from a Medical practitioner, podiatric surgeon or a podiatrist. Referrals from any other source may be claimed under the appropriate non-referred visit health service code.

GR 4.4.8 Add HSC: 03.01O Physician to physician E-consultation, consultant.

AMA NOTE: this change means that in order to submit a claim, a valid referring PRACID is required.

GR 18.1 The Body Mass Index (BMI) modifier may be claimed for selected procedures, obstetrical services, anaesthesia, second qualified surgeon and surgical assistant services provided in any location when the following criteria are met:
a) An adult patient has a body mass index of 35 or more.
b) A patient under 18 years of age who is above the 97th percentile for BMI on an approved pediatric growth curve

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

AMA NOTES: The BMI modifier has changed from its previous BMISRG to the new BMIPRO.

• The New BMIPRO modifier is used in place of the BMISRG and is billable when the patient has met the criteria for BMI.
• BMIPRO may only be claimed for procedures that have BMIPRO listed in the Price List of the Schedule of Medical Benefits. www.health.alberta.ca/professionals/SOMB.html
• BMIPRO is billable for listed procedures in ANY location including the physician’s office.
Procedures that were previously listed as having BMISRG may still be submitted for additional payment using the BMIPRO modifier.

Only one code was added to the list of eligible services: 13.99BC the new code for pap smear and/or pelvic swab.

03.01O  Physician to Physician E-Consultation, consultant

**AMA NOTES:** if claiming 03.01O, a referral PRACID is required.

03.02A  Brief assessment of a patient’s condition requiring a minimal history with little or no physical examination.

**AMA NOTES:** this change incorporates the definition of a brief assessment from the Governing Rules into the description of the service.

03.03A  Limited assessment of a patient’s condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient

**AMA NOTES:** this change incorporates the definition of a limited assessment from the Governing Rules into the description of the service.

03.04A  Comprehensive assessment of a patient’s condition requiring a complete history, a complete physical examination appropriate to the physician’s specialty, an appropriate record and advice to the patient

**AMA NOTES:** this change incorporates the definition of a comprehensive assessment from the Governing Rules into the description of the service.

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

**NOTE:** 1. May only be claimed when an examination and a standard form for pre-operative assessment have been completed.

2. A copy of the form must be retained in the patient’s chart.
03.05JP  Family conference via telephone relating to acute care facility in-patient or registered emergency or out-patient, or auxiliary hospital, nursing home patient, AACC or UCC patient  
$40.11
NOTE: 1. Intended specifically for patients whose condition warrants periodic family conferences or for patients who are unable to properly communicate with their physician (e.g., situations where there is a language barrier, unconscious patient, etc.).
2. This service is to be claimed using the Personal Health Number of the patient.
3. May be claimed in situations where:
a) location or mobility factors of family members at the time of the call preclude in person meetings.
b) timely communication with family members is essential to patient care or organ/tissue transfer collection, and
c) communication about a patient’s condition or to gather collateral information that is relative to patient management and care activities.
4. May not be claimed for:
a) relaying results for lab or diagnostics.
b) arranging follow up care.
5. Documentation of the communication to be maintained in the patient record.

03.05JQ  Family conference with relative(s) via telephone in connection with the management of a patient with a psychiatric disorder  
$50.66
NOTE: 1. This service is to be claimed using the Personal Health Number of the patient.
2. May be claimed in situations where:
a) the patient’s family is to be notified of a mental health crisis.
b) location or mobility factors of family members at the time of the call preclude in person meetings.
c) timely communication with family members is essential to patient care and/or management.
d) communication about a patient’s condition is required to gather collateral information that is relative to the patient management and care activities.
3. May not be claimed for:
a) relaying results for lab or diagnostics.
b) gathering information that is in relation to the development of a Community Treatment Order (CTO).
c) arranging for follow-up care.
4. Documentation of the communication and relationship of family member to the patient must be recorded in the patient record.
03.05JR  Physician telephone call directly to patient, to discuss patient management/diagnostic test results  
$15.12
NOTE: 1. A maximum of 7 telephone calls per physician, per calendar week may be claimed.
2. May not be claimed for management of patient’s anticoagulant therapy (billable under HSC 03.01N).
3. May not be claimed when communication is with a proxy for the physician.
4. Documentation of the communication to be recorded in the patient record.

08.19G  Direct contact with an individual patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or general psychiatric counselling, per 15 minutes or major portion thereof

**AMA NOTES:** this change requires that a physician spend a minimum of 8 minutes after the first full 15 minutes in order to submit a claim for a second or subsequent call.

13.99BA  Delete HSC

Periodic Papanicolaou Smear

**AMA NOTES:** Please see new code 13.99BC.

13.99BC  Pelvic examination requiring swab and or sample collection, includes Periodic Papanicolaou Smear  
$27.80
NOTE: 1. Two Papanicolaou smears may be claimed per patient, per physician, per year (April 1 of one year to March 31 of the following year). Additional claims may be submitted with supporting information.
2. May be claimed with a visit or consultation.

**AMA NOTES:** claims for pap smears may be claimed using the 13.99BC, physicians do not have to complete a swab and a pap smear at the same encounter in order to submit a claim. If a pap and a swab are completed at the same encounter, only one service may be claimed.

13.99EA  Delete HSC

Resuscitation in an AACC or UCC, full 60 minutes or a portion thereof for the first call when only one call is claimed.

**AMA NOTES:** Claims for resuscitation in AACC or UCC’s should be submitted using HSC 13.99E.
13.99EC  Resuscitation, per 15 minutes or major portion thereof for the second and subsequent physician actively participating and providing assistance to the primary physician at a resuscitation  

$87.66

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 only be claimed for the time spent when the physician is directly involved in assisting the primary physician in a resuscitation.
3. May not be claimed in addition to other procedures or visits at the same encounter by the same physician.
4. May not be claimed for Medical Emergency Team (MET) coverage.
SECTION OF ANESTHESIA

16.91G  Epidural analgesia for labour and delivery, monitoring and/or top-up/adjustment, each additional full 5 minutes, per patient

Amend Note 2:
2. 16.91G may not be claimed for the same patient until 35 minutes has elapsed from the time of the initiation of the 16.91C recognizing that HSC 16.91C represents a full 30 minutes.

AMA NOTES: This change clarifies that the initial set up of the epidural consumes the first 30 minutes and the 16.91G may be claimed once a full 5 minutes has elapsed after the first 30 minutes.
### SECTION OF DERMATOLOGY

- **98.93A**  
  Less than 1/4 of face  
  *NOTE: Refer to notes following 98.93C. May only be claimed when performed in an operating or day surgery room in an active treatment facility.*

- **98.93B**  
  Between 1/4 and 1/2 of face  
  *NOTE: Refer to notes following 98.93C. May only be claimed when performed in an operating or day surgery room in an active treatment facility.*

- **98.93C**  
  **Delete HSC**  
  Full face  
  *NOTE: HSCs 98.93A, 98.93B and 98.93C may only be claimed when performed in an operating or day surgery room in an active treatment facility.*
### SECTION OF DIAGNOSTIC IMAGING

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SECTION OF EMERGENCY MEDICINE

**03.01LT**
Online medical control (OLMC) – Telephone calls from EMS practitioners on site to OLMC physicians on duty

$27.88

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

2. May only be claimed when the OLMC physician has provided an opinion and recommendations for patient management to the EMS practitioner after reviewing the patient’s history and condition with the EMS practitioner as well as review of laboratory and other data where indicated.

3. May not be claimed for situations where the purpose of the call is to:
   - arrange for an expedited consultation or procedure within 24 hours except when the conditions in note 2 are met.
   - arrange for laboratory or diagnostic investigations.

4. A maximum of two claims may be claimed per patient, per physician, per day.

5. Documentation of the phone call must be recorded in their respective records.

**10.04B**
Intubation performed in an emergency room, AACC or UCC

NOTE: 1. May only be claimed when performed in an emergency room, AACC or UCC.

2. May not be claimed in addition to HSC 10.04 or 13.99E or 13.99EA when performed by the same physician.

3. May be claimed in addition to visits or other services provided on the same day by the same physician.

**13.99BA**
Delete HSC
Periodic Papanicolaou Smear

**AMA NOTE:** Please see new code 13.99BC.

**13.99BC**
Pelvic examination requiring swab and or sample collection, includes Periodic Papanicolaou Smear

$27.80

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

2. May be claimed with a visit or consultation.

**AMA NOTES:** claims for pap smears may be claimed using the 13.99BC, physicians do not have to complete a swab and a pap smear at the same encounter in order to submit a claim. If a pap and a swab are completed at the same encounter, only one service may be claimed.
13.99EA  **Delete HSC**
Resuscitation in an AACC or UCC, full 60 minutes or a portion thereof for the first call when only one call is claimed.

**AMA NOTES:** Claims for resuscitation in AACC or UCC's should be submitted using HSC 13.99E.

13.99EC  Resuscitation, per 15 minutes or major portion thereof for the second and subsequent physician actively participating and providing assistance to the primary physician at a resuscitation

$87.66

**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 only be claimed for the time spent when the physician is directly involved in assisting the primary physician in a resuscitation.
3. May not be claimed in addition to other procedures or visits at the same encounter by the same physician.
4. May not be claimed for Medical Emergency Team (MET) coverage.

13.99J  Amend Note 9:
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 patients may not be claimed.

13.99VA  **Delete HSC**
Examination and crisis counselling for sexual/physical abuse in an AACC or UCC, full 15 minutes or major portion thereof for the first call when only one call is claimed.

**AMA NOTES:** Claims for this service should move to 13.99V.
SECTION OF GASTROENTEROLOGY

57.13A  Amend wording as indicated and delete LVP ADD rate
Bipolar electrocoagulation/heater probe haemostasis or endoclip placement or argon plasma coagulation for bleeding lesions of the colon, additional benefit

57.21B  Amend wording as indicated and delete LVP ADD rate
Injection haemostasis, additional benefit
For vascular abnormalities of colon
SECTION OF GENERAL INTERNAL MEDICINE

03.03FA  Prolonged repeat office or scheduled outpatient visit in a regional facility, referred cases only, full 15 minutes or portion thereof for the first call when only one call is claimed.

NOTE: 1) May only be claimed in addition to HSC 03.03F when the 03.03F exceeds 30 minutes.
2) May only be claimed by pediatrics (including subspecialties) and clinical immunology, and allergy for patients 18 years of age and under, or by cardiology, endocrinology/metabolism, infectious diseases, internal medicine, hematology, medical genetics, physiatry, urology, rheumatology, and vascular surgery (no age restriction).

Add skill CLIM with age restriction of 18 and under in the Price List.
03.03FA  25.05  SKLL CLIM  Replace Base  46.99

03.05H  Medical examination, including completion of form, required pursuant to the Traffic Safety Act to obtain or renew an operator’s license, where the patient is 74.5 years of age or older.

ADD the CMXV30 to the Price List:
   CARE CMXV30- Y  Increase Base By  31.11

AMA NOTES: The CMXV30 modifier has been added to the 03.05H for those services that take 30 minutes or longer. This change was made to accommodate the extended time that some assessment’s may take longer due to complexity or due to the patient requesting that other conditions be considered by the physician at the same encounter.
SECTION OF GENERAL PRACTICE

03.02A Brief assessment of a patient’s condition requiring a minimal history with little or no physical examination.

AMA NOTES: this change incorporates the definition of a brief assessment from the Governing Rules into the description of the service.

03.03A Limited assessment of a patient’s condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient.

NOTE: Benefit includes the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient.

AMA NOTES: this change incorporates the definition of a limited assessment from the Governing Rules into the description of the service.

03.04A Comprehensive assessment of a patient’s condition requiring a complete history, a complete physical examination appropriate to the physician’s specialty, an appropriate record and advice to the patient.

NOTE: 1. This may be used for an annual medical examination within the limitations of GR 4.6.1.

2. Complete physical examination shall encompass all those organ systems which customarily and usually are the standard complete examination prevailing within the practice of the respective specialty.

3. Benefit includes the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient.

AMA NOTES: this change incorporates the definition of a comprehensive assessment from the Governing Rules into the description of the service.

03.04K Amend text of Note 7b):

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 and assessment of senior falls.

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

NOTE: 1. May only be claimed when an examination and a standard form for pre-operative assessment have been completed.

2. A copy of the form must be retained in the patient’s chart.
03.05H Medical examination, including completion of form, required pursuant to the Traffic Safety Act to obtain or renew an operator’s license, where the patient is 74.5 years of age or older.

**ADD** the CMXV30 to the Price List:

```
CARE CMXV30   Y  Increase Base By  31.11  V
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**AMA NOTES:** The CMXV30 modifier has been added to the 03.05H for those services that take 30 minutes or longer. This change was made to accommodate the extended time that some assessment’s may take longer due to complexity or due to the patient requesting that other conditions be considered by the physician at the same encounter.

08.19G Direct contact with an individual patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or general psychiatric counselling, per 15 minutes or major portion thereof

**AMA NOTES:** this change requires that a physician spend a minimum of 8 minutes after the first full 15 minutes in order to submit a claim for a second or subsequent call.

13.99J Amend Note 9:

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 patients may not be claimed.

13.99VA **Delete** HSC

Examination and crisis counselling for sexual/physical abuse in an AACC or UCC, full 15 minutes or major portion thereof for the first call when only one call is claimed.

**AMA NOTES:** claims for this service should move to 13.99V.

13.99BA **Delete** HSC

Periodic Papanicolaou Smear

**AMA NOTES:** Please see new code 13.99BC.

13.99BC Pelvic examination requiring swab and or sample collection, includes Periodic Papanicolaou Smear

```
$27.80
```

**NOTE:**
1. Two Papanicolaou smears may be claimed per patient, per physician, per year (April 1 of one year to March 31 of the following year). Additional claims may be submitted with supporting information.
2. May be claimed with a visit or consultation.

**AMA NOTES:** claims for pap smears may be claimed using the 13.99BC, physicians do not have to complete a swab and a pap smear at the same encounter in order to submit a claim. If a pap and a swab are completed at the same encounter, only one service may be claimed.
13.99EA  Delete HSC
Resuscitation in an AACC or UCC, full 60 minutes or a portion thereof for the first call when only one call is claimed.

**AMA NOTES: Claims for resuscitation in AACC or UCC’s should be submitted using HSC 13.99E.**

13.99EC  Resuscitation, per 15 minutes or major portion thereof for the second and subsequent physician actively participating and providing assistance to the primary physician at a resuscitation $87.66

**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 only be claimed for the time spent when the physician is directly involved in assisting the primary physician in a resuscitation.
3. May not be claimed in addition to other procedures or visits at the same encounter by the same physician.
4. May not be claimed for Medical Emergency Team (MET) coverage.

13.99J  Amend Note 9:
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 patients may not be claimed.

95.94A  Injection with local anaesthetic of myofascial trigger points combined with a spray and stretch technique

**NOTE:** 30 minutes of stretching is required at the time of the injection.

CMXV30 CMXV30 COMPLEX PATIENT CONSULTATION/VISIT -(Explicit) -
This modifier is used to indicate a complex patient consultation or visit requiring that the physician spend 30 minutes or more on management of the patient's care. Refer to modifier CMXV15 for visits less than 30 minutes.

May only be claimed by:
- community medicine, geriatric medicine, occupational medicine, radiation oncology for HSCs 03.03A, 03.07A, 03.07B.
- cardiology, endocrinology/metabolism, haematology, infectious diseases, internal medicine, medical oncology, nephrology, pediatric cardiology, pediatrics, **rheumatology** for HSCs 03.03A, 03.03F, 03.07A, 03.07B.

Pediatrics may claim for HSC 03.05JK.
- general practice for HSC 03.05H only.

**AMA NOTES: The CMXV30 modifier has been added to the 03.05H for those services that take 30 minutes or longer. This change was made to accommodate the extended time that some assessment’s may take longer due to complexity or due to the patient requesting that other conditions be considered by the physician at the same encounter.**
SECTION OF GENERAL SURGERY

GR 6.8.1e)   HSC 03.04R may be claimed in the pre-operative time frame when all conditions in the notes have been met

**AMA NOTES: 03.04R may only be claimed by GNSG once per patient in the pre-operative period following a consultation.**

GR 6.9.7e)   Add HSC: 65.1 A Repair of recurrent inguinal or femoral hernia, including mesh if used

03.04R   Pre-surgical planning and patient navigation visit
NOTE: 1. May only be claimed by general surgery.
2. May only be claimed for patients that have already received a consultation in the pre-operative period by the same physician who intends on performing the procedure.
3. May only be claimed in instances where more than one pre-surgical visit is necessary due to the complexities of the patients’ circumstances and/or surgical needs.
4. May only be claimed in the pre-operative period for procedures with a category code of 3, 4, 6 or 14.

<table>
<thead>
<tr>
<th>Description</th>
<th>Rate</th>
<th>Skill Code</th>
<th>Replace Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>03.04R</td>
<td>75.40</td>
<td>GNSG</td>
<td>75.40 V</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PSDG</td>
<td>75.40</td>
</tr>
</tbody>
</table>

**AMA NOTES: this code may be claimed once in the pre-operative period following the initial consult.**

03.03D   Daily hospital care
Add skill GNSG to Price List

<table>
<thead>
<tr>
<th>Description</th>
<th>Rate</th>
<th>Skill Code</th>
<th>Replace Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEVL GNSGH1</td>
<td>42.22</td>
<td>GNSG</td>
<td>42.22</td>
</tr>
<tr>
<td>LEVL GNSGH2</td>
<td>30.47</td>
<td>GNSG</td>
<td>30.47</td>
</tr>
</tbody>
</table>

03.040   Follow-up care of patient with functioning renal transplant – first year
NOTE: 1) May only be claimed 4 times per patient within the first 12 months following a renal transplant.
2) Should the required number of visits exceed four within a given post-transplant year (beginning on the date of transplantation), subsequent visit may be submitted using the appropriate visit HSC.
3) May only be claimed by physicians with NEPH or GNSG skill code.
Add skill GNSG to price list

<table>
<thead>
<tr>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>SKLL GNSG</td>
<td>99.53</td>
</tr>
</tbody>
</table>
Follow-up care of patient with functioning renal transplant – second and subsequent years

NOTE: 1) May only be claimed 4 times per patient for the second and subsequent years following a renal transplant.

2) Should the required number of visits exceed four within a given post-transplant year (beginning on the date of transplantation), subsequent visit may be submitted using the appropriate visit HSC.

3) May only be claimed by physicians with NEPH or GNSG skill code.

Add skill GNSG to price list

SKLL GNSG  Replace Base  99.53

Decompression recurrent laryngeal nerve

NOTE: May only be claimed in addition to thyroid surgery (HSCs 19.3 A or 19.3 B) when the nerve is encased in malignant disease or in repeat thyroid procedures.

Delete HSC

Cervical sympathectomy

Delete HSC

Other partial thyroidectomy NEC

Subtotal thyroidectomy

Delete HSC

Partial excision of thymus

Delete HSC

Radical or block neck dissection

Complete, unilateral including removal of all neck lymph nodes and non-lymphatic structures, (e.g., sternocleidomastoid muscle, jugular vein and spinal accessory nerve)

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

Delete HSC

Esophagotomy for removal of tumor, transthoracic

Delete HSC

Esophageal motility study and pH monitoring of distal esophagus, technical

Sleeve gastrectomy for obesity  $1,010.38

NOTE: May not be claimed in addition to HSC 66.83.
<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>56.93D</td>
<td>Removal of gastric band</td>
<td>$693.69</td>
</tr>
<tr>
<td></td>
<td>NOTE: May not be claimed in addition to HSC 66.83.</td>
<td></td>
</tr>
<tr>
<td>56.93E</td>
<td>Port revision or replacement</td>
<td>$361.93</td>
</tr>
<tr>
<td>57.6 F</td>
<td><strong>Delete LVP ADD rate</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Colon or j-pouch or coloplasty construction, additional benefit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NOTE: May only be claimed in addition to HSC 60.52A</td>
<td></td>
</tr>
<tr>
<td>57.13A</td>
<td>Amend wording as indicated and delete LVP ADD rate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bipolar electrocoagulation/heater probe haemostasis or endoclip placement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>or argon plasma coagulation for bleeding lesions of the colon, <strong>additional benefit</strong></td>
<td></td>
</tr>
<tr>
<td>57.21B</td>
<td>Amend wording as indicated and delete LVP ADD rate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Injection haemostasis, <strong>additional benefit</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For vascular abnormalities of colon</td>
<td></td>
</tr>
<tr>
<td>59.0</td>
<td><strong>Delete HSC</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appendectomy</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>AMA NOTES: Please see 59.1A. Claims for appendectomies should be made using 59.1A for dates of service April 1, 2015 and onwards.</strong></td>
<td></td>
</tr>
<tr>
<td>59.1 A</td>
<td>Appendectomy with <strong>or without</strong> abscess</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Note: May not be claimed for incidental appendectomies</strong></td>
<td></td>
</tr>
<tr>
<td>60.65</td>
<td>Add an LVP ADD rate to this procedure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Abdominal proctopexy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NOTE: May be claimed in addition to HSC 60.52A</td>
<td></td>
</tr>
<tr>
<td>65.01A</td>
<td>Repair of inguinal hernia, <strong>incarcerated, obstructed or strangulated</strong></td>
<td></td>
</tr>
<tr>
<td>65.01C</td>
<td><strong>Delete HSC</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Repair of inguinal hernia</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>AMA NOTES: Claims should move to HSC 65.01A.</strong></td>
<td></td>
</tr>
<tr>
<td>65.1 A</td>
<td>Repair of recurrent inguinal or femoral hernia, including mesh if used</td>
<td>$639.40</td>
</tr>
<tr>
<td>65.11A</td>
<td><strong>Delete HSC</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Repair of recurrent inguinal hernia, including mesh, if used</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>AMA NOTES: Claims should move to HSC 65.1 A.</strong></td>
<td></td>
</tr>
</tbody>
</table>
65.14A  **Delete HSC**
Repair of recurrent femoral hernia, including mesh, if used

*AHA NOTES: Claims should move to HSC 65.1 A.*

65.7 A  Repair of diaphragmatic hernia, abdominal approach, acquired
NOTE: When performed with HSCs 56.93A or 56.93C, the benefit will be paid as ADD

65.7 D  Repair of congenital diaphragmatic hernia for infant 14 days of age and younger

67.59A  Renal transplantation (homo, hetero, auto)
NOTE: 1. Includes intra-operative renal biopsy.
2. May not be claimed in addition to HSCs 68.72A or 68.72C.

68.72A  Ureteroneocystostomy
NOTE: May not be claimed in addition to HSC 67.59A.

68.72C  Ureteroneocystostomy with bladder flap
NOTE: May not be claimed in addition to HSC 67.59A.
### SECTION OF GENERALISTS IN MENTAL HEALTH

Add skill GNMH to the Price List for the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Replace Base</th>
<th>Rate</th>
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</thead>
<tbody>
<tr>
<td>03.01B</td>
<td>SKLL GNMH</td>
<td>Replace Base</td>
<td>27.91</td>
</tr>
<tr>
<td>03.01BA</td>
<td>SKLL GNMH</td>
<td>Replace Base</td>
<td>29.55</td>
</tr>
<tr>
<td>03.01BB</td>
<td>SKLL GNMH</td>
<td>Replace Base</td>
<td>34.47</td>
</tr>
</tbody>
</table>

08.19G  Direct contact with an individual patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or general psychiatric counselling, per 15 minutes or **major** portion thereof

**AMA NOTES: this change requires that a physician spend a minimum of 8 minutes after the first full 15 minutes in order to submit a claim for a second or subsequent call.**
### SECTION OF NEUROLOGY

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.85A</td>
<td><strong>Delete HSC</strong> Injection of contrast media, via fontanelle</td>
</tr>
<tr>
<td>17.1 B</td>
<td><strong>Delete HSC</strong> Injection of alcohol, retrobulbar</td>
</tr>
</tbody>
</table>
SECTION OF OBSTETRICS AND GYNECOLOGY

13.99BA  Delete HSC
Periodic Papanicolaou Smear

**AMA NOTES: Please see new code 13.99BC.**

13.99BC  Pelvic examination requiring swab and or sample collection, includes Periodic Papanicolaou Smear  
**$27.80**

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

2. May be claimed with a visit or consultation.

**AMA NOTES: claims for pap smears may be claimed using the 13.99BC, physicians do not have to complete a swab and a pap smear at the same encounter in order to submit a claim. If a pap and a swab are completed at the same encounter, only one service may be claimed.**

66.83  Laparoscopy  
Diagnostic, with or without biopsy

NOTE: 1. May not be claimed in addition to other procedures if the laparoscopy is an integral part of the procedure with the exception of HSCs 62.12B, 81.09, 82.63, or 83.2 B or 86.49A, which may be claimed at 100%.

2. May be claimed in addition to HSCs 55.8 A, 55.8 B, 55.8 C, 55.8 D, 55.9 A, 55.99A, 55.9 B, 55.9 C, 64.43A, 64.49.

82.0 A  Delete HSC  
Culdocentesis  
**NOTE: Includes D&C**

86.49A  Delete HSC  
Injection of prostaglandins into ectopic pregnancy  
**NOTE: May only be claimed in addition to 66.83**
SECTION OF OPHTHALMOLOGY

GR 6.8.4e) Add HSC: 22.13C Excision of benign tumor of eyelid not requiring pathology analysis

GR 13.3 Add HSC: 22.13C Excision of benign tumor of eyelid not requiring pathology analysis
Delete HSCs: 22.11A
AMA NOTE: 22.13C replaces 22.11A Excision of benign tumor of eyelid not requiring pathology analysis.

GR 14.1 Add HSC: 22.13C Excision of benign tumor of eyelid not requiring pathology analysis
Delete HSCs: 22.11A
AMA NOTE: 22.13C replaces 22.11A Excision of benign tumor of eyelid not requiring pathology analysis.

GR 15.10.6 Add HSC: 22.13C Excision of benign tumor of eyelid not requiring pathology analysis

09.13D Ocular ultrasonography, for intraocular pathology, interpretation
Change category code from a minor procedure (M) to a test (T)

22.11A Delete HSC
Excision of benign tumor of lid not requiring pathology analysis

22.13C Excision of benign tumor of eyelid not requiring pathology analysis $79.07

22.51A Functional blepharoplasty – upper eyelid – without cosmetic intent
NOTE: May only be claimed for patients 65 years or older where at least half the pupil is covered by the skin of the upper eyelids.

23.99A Strabismus repair, one muscle
NOTE 1) Subsequent muscles, regardless if the same or different eye, are paid at a reduced rate as indicated in the Price List to a maximum benefit of five.
2) The add on fee applies once per eye for re-operation.
Amend Price List as indicated:
CALL NBRSER
  1 For Each Call Pay Base At 100%
  2-6 For Each Call Pay Base At 56%
REDO REANE Y Increase By 59.27
REDO REOP Y Increase Base To 137%
26.97B Placement of radioactive plaque with suturing to sclera
Add modifiers in the Price List as indicated:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Base</th>
<th>Modifier Y</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.97B 822.55</td>
<td>ROLE SA</td>
<td>146.54</td>
<td>Replace Base</td>
<td>100%</td>
</tr>
<tr>
<td>ROLE SAQS</td>
<td>50.45</td>
<td>Replace Base</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAU</td>
<td>For Each Call Pay Base At</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>For Each Call Increase By</td>
<td>36.67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAQU</td>
<td>For Each Call Pay Base At</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-36</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

28.71A Anterior vitrectomy with port infusion and cutting device using automated vitrector at the time of anterior segment surgery (complex cataract, trauma, keratoplasty, glaucoma filtering procedure)

29.02A Remove orbital tumor posterior to globe – first 90 minutes
Amend Price List as indicated:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Base</th>
<th>Modifier M90M15</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>For Each Call Pay Base At</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>For Each Call Increase By</td>
<td>11%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CORNEAL CROSSLINKING (CXL)
Alberta Health has completed a review of the corneal cross-linking (CXL) for the treatment of corneal thinning disorders, including keratoconus. Based on the results of the provincial review and recommendations from the Alberta Advisory Committee on Health Technologies (AACHT) Alberta Health has made the decision to fund CXL epithelium off procedure for select patient population.

In order to be eligible for the procedure, patients must have a greater than 1 Dioptrre change in refractive astigmatism and a greater than one line loss of corrected acuity documented over a minimum of three examinations (one baseline and two follow ups). In addition, CXL may not be claimed for services provided in association or relation to refractive surgery EITHER 2 YEARS PRECEDING REFRACTIVE SURGERY OR 2 YEARS FOLLOWING REFRACTIVE SURGERY.

Alberta Health (AH) will be introducing CXL procedure as an insured service into the Schedule of Medical Benefits (SOMB) at a later date. In the meantime, any ophthalmologist performing this service, may bill for CXL epithelium off procedure under HSC 99.09C. Alberta Health will pay entire CXL procedure submitted under 99.09C.

This service can be performed in a physician’s office and there is NO requirement to have a contract for the NHSF.

Please submit all services for CXL to Alberta Health under fee code 99.09C (both professional and technical components in one claim).
Please review section 3.7 Submitting Claim for Unlisted Procedures from the physician resource guide at the following link to guide you through the submission process for a 99.09 claim: www.health.alberta.ca/documents/Physician-Resource-Guide-2014.pdf
SECTION OF ORTHOPEDICS

90.39A  Incremental lengthening or deformity correction using external fixation device, full 60 minutes or major portion thereof for the first call when only one call is claimed

93.09B  Arthrodesis sacro-iliac or instrumentation sacrum to pelvis

93.12A  Single hindfoot joint fusion or syndesmosis fusion

98.41A  Delete HSC
Skin graft in association with varicose vein operation, additional benefit
NOTE: May only be claimed in addition to HSC 50.4 F
### SECTION OF OTOLARYNGOLOGY

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.39F</td>
<td>Decompression recurrent laryngeal nerve</td>
<td>NOTE: May only be claimed in addition to thyroid surgery (HSCs 19.3 A or 19.3 B) when the nerve is encased in malignant disease or in repeat thyroid procedures.</td>
</tr>
<tr>
<td>18.12</td>
<td><strong>Delete HSC</strong> Cervical sympathectomy</td>
<td></td>
</tr>
<tr>
<td>19.29</td>
<td><strong>Delete HSC</strong> Other partial thyroidectomy NEC Subtotal thyroidectomy</td>
<td></td>
</tr>
<tr>
<td>20.72</td>
<td><strong>Delete HSC</strong> Partial excision of thymus</td>
<td></td>
</tr>
<tr>
<td>52.32</td>
<td><strong>Delete HSC</strong> Radical or block neck dissection</td>
<td>Complete, unilateral including removal of all neck lymph nodes and non-lymphatic structures, (e.g., sternocleidomastoid muscle, jugular vein and spinal accessory nerve) NOTE: May not be claimed with 17.08G, 50.72C, 95.14E.</td>
</tr>
<tr>
<td>54.29B</td>
<td><strong>Delete HSC</strong> Esophagotomy for removal of tumor, transthoracic</td>
<td></td>
</tr>
<tr>
<td>54.89C</td>
<td><strong>Delete HSC</strong> Esophageal motility study and pH monitoring of distal esophagus, technical</td>
<td></td>
</tr>
</tbody>
</table>
SECTION OF PEDIATRICS

03.03DG  Complex pediatric hospital visit per full 15 minutes
NOTES: 1) May only be claimed for visits where the patient is complex
and requires a minimum of 20 minutes on patient care management.
2) May not be claimed on the same date of service as any visit service by the same
physician.
3) Time may be claimed on a cumulative basis.
4) May only be claimed by pediatricians and pediatric subspecialties.
Amend the Price List as indicated:
61.80   CALL M15   V
1-40   For Each Call Pay Base At 100%
2-10   For Each Call Pay Base At 61%
AMA NOTES: this service will continue to be paid on time, the amendments are to the
rates paid for the first time unit and for the subsequent time units. This will make the
service payable at rates that are in line with the pediatric fee schedule.

03.08G  Delete HSC
Prolonged consultation or hospital admission by pediatrics (including subspecialties) for
patients 18 years of age and under, or by medical genetics (no age restriction), full 15
minutes or portion thereof for the first call when only one call is claimed.
AMA NOTES: This code will be deleted, please see amendments to 03.08J. Prolonged
consults for pediatrics including subspecialties should be claimed using HSC 03.08J.

03.08J  Prolonged consultation or hospital admission by pediatrics (including subspecialties) and clinical immunology and allergy for patients 18 years of age and under, or by medical genetics (no age restriction), full 15 minutes or portion thereof for the first call when only one call is claimed.
NOTE: May only be claimed:
- for services other than those described under HSC 03.08G;
- in addition to HSC 03.08A and 03.04C after 30 minutes;
- in addition to HSC 03.07A and 03.07B after 20 minutes.
AMA NOTES: claims for 03.08G should be submitted using HSC 03.08J for dates of
service April 1, 2015 and onwards.

03.19D  Change category code from a minor procedure (M) to a test (T)
Sleep polygraph studies for apnea and SIDS, interpretation
NOTE: Pediatric specialty restriction.

13.01A  Delete HSC
Exchange transfusion
NOTE: May only be claimed for an infant who is 3 months of age or younger.
SECTION OF PHYSICAL MEDICINE AND REHABILITATION

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>03.05LB</td>
<td>Group teaching session for patients and/or family members with chronic pain, previous amputation, stroke, brain injury, concussion, spinal cord injury, or other neuromusculoskeletal condition, first 45 minutes or major portion thereof for the first call when only one call is claimed</td>
<td>$252.08</td>
</tr>
</tbody>
</table>

NOTE: May not be claimed for preparation time.

AMA NOTES: May only be claimed by physicians with PHMD skill code.

NBPG NUMBER OF PATIENTS IN GROUP - (Explicit) - Used to indicate the number of people in a psychiatric, or teaching group. A two digit numeric character must be added to the modifiers' alpha character, example: NBPG08. This two digit numeric character represents the number of people participating in the psychiatric or teaching group. Depending on the skill indicated the rate is divided by the number of people to determine the rate per person per 15 minutes.

This modifier will be used in conjunction with the appropriate units modifier that is based on time, and is derived from the calls field used if the visit exceeds 15 minutes.

NBPG NUMBER OF PATIENTS IN GROUP - (Explicit) - Used by both, Fee-for-Service and Mental Health Sessional Practitioners on sessional payments to indicate the number of people participating in group psychotherapy, or teaching services.

Example: NBPG10, divide the rate by the number of people to determine the rate per patient per 15 minutes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>95.94A</td>
<td>Injection with local anaesthetic of myofascial trigger points combined with a spray and stretch technique</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: 30 minutes of stretching is required at the time of the injection.
SECTION OF RESPIRATORY MEDICINE

GR 11.2.1 PULMONARY FUNCTION PROCEDURES
Physicians performing procedures identified as Level I do not require approval from the CPSA to perform these services. These services are reflected in HSCs 03.37A, 03.37B, 03.38D, 03.38E and 03.38R. Physicians performing procedures identified by the CPSA as requiring either Level II, III or IV require approval and may only be claimed by physicians with the appropriate level of CPSA approval. In addition to Level I procedures, physicians with Level II approval may claim:

03.38A 03.38B 03.38C 03.38F 03.38G

In addition to Level I and Level II procedures, physicians with Level III approval may claim:

03.38H 03.38J 03.38K 03.38M 03.38N 03.38P
03.38Q 03.38R 03.38T 03.38X

In addition to Level I, II and III procedures, physicians with Level IV approval may claim:

03.38V

03.38J Delete HSC
End alveolar CO2

03.38V Delete HSC
Bronchospirometry
SECTION OF RHEUMATOLOGY

03.03FA  **Add skill RHEU to list of eligible skills with no age restriction**
Prolonged repeat office or scheduled outpatient visit in a regional facility, referred cases only, full 15 minutes or portion thereof for the first call when only one call is claimed.
NOTE: 1) May only be claimed in addition to HSC 03.03F when the 03.03F exceeds 30 minutes.
2) May only be claimed by pediatrics (including subspecialties) and clinical immunology, and allergy for patients 18 years of age and under, or by cardiology, endocrinology/metabolism, infectious diseases, internal medicine, hematology, medical genetics, psychiatry, urology, **rheumatology**, and vascular surgery (no age restriction).

03.03FA  **SKLL RHEU**  **Replace Base**  **34.97**

03.08I  **Add skill RHEU to fee code**
Prolonged endocrinology/metabolism, gastroenterology, hematology, infectious diseases, internal medicine, nephrology, psychiatry, neurology or rheumatology consultation or visit, full 15 minutes or major portion thereof for the first call when only one call is claimed.

Add skill RHEU to price list

03.08I  **SKLL RHEU**  **Replace Base**  **44.06**

CMXV15  **CMXV15 COMPLEX PATIENT CONSULTATION/VISIT** - (Explicit) - **Add RHEU to the list of skills eligible to claim this modifier**

CMXV30  **CMXV30 COMPLEX PATIENT CONSULTATION/VISIT** - (Explicit) -
This modifier is used to indicate a complex patient consultation or visit requiring that the physician spend 30 minutes or more on management of the patient's care. Refer to modifier CMXV15 for visits less than 30 minutes.
May only be claimed by:
- community medicine, geriatric medicine, occupational medicine, radiation oncology for HSCs 03.03A, 03.07A, 03.07B.
- cardiology, endocrinology/metabolism, haematology, infectious diseases, internal medicine, medical oncology, nephrology, pediatric cardiology, pediatrics, **rheumatology** for HSCs 03.03A, 03.03F, 03.07A, 03.07B.
Pediatrics may claim for HSC 03.05JK.
- **general practice for HSC 03.05H only.**

**AMA NOTES: RHEU will be removed from CMXV20 and CMXV35 effective April 1, 2015.**
SECTION OF THORACIC SURGERY

45.24  Delete HSC
Thoracoplasty
That for collapse lung
### SECTION OF UROLOGY

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>67.59A</td>
<td>Renal transplantation (homo, hetero, auto)</td>
<td>1. Includes intra-operative renal biopsy.  2. May not be claimed in addition to HSCs 68.72A or 68.72C.</td>
</tr>
<tr>
<td>68.72A</td>
<td>Ureteroneocystostomy</td>
<td>NOTE: May not be claimed in addition to HSC 67.59A.</td>
</tr>
<tr>
<td>68.72C</td>
<td>Ureteroneocystostomy with bladder flap</td>
<td>NOTE: May not be claimed in addition to HSC 67.59A.</td>
</tr>
</tbody>
</table>
### SECTION OF VASCULAR SURGERY

**GR 6.15.4** Add HSC: 51.21C Bidirectional cavopulmonary anastomosis

50.4 F Radical multiple ligation of incompetent communicating veins of lower leg (extrafascial ligation or Cockett procedure, subfascial ligation) excludes stripping of long saphenous vein

*NOTE: Excision of fascia of calf or skin graft, code HSC 95.35A or 98.41A may be claimed in addition.*

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>50.34DA</td>
<td>Endovascular repair of thoracic aneurysm</td>
<td>$2,154.21</td>
</tr>
<tr>
<td>51.21C</td>
<td>Bidirectional cavopulmonary anastomosis</td>
<td>$2,530.98</td>
</tr>
<tr>
<td>51.93A</td>
<td>Delete HSC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Arteriovenous cannulation</td>
<td></td>
</tr>
</tbody>
</table>