

Billing Corner



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Billing Corner is also available on the
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April 2016

Please read this document and then share with your billing staff

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

Electronic copy:

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

**Alberta Health Care Insurance Plan
Schedule of Medical Benefits
Changes for April 1, 2016**

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

HIGHLIGHTS

The changes noted below will affect **ALL** physicians, please read carefully and share with your staff. These changes will become effective April 1, 2016.

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

NEW ELECTRONIC COMMUNICATION CODES:

- 03.01R Physician to Physician secure E-Consultation, referring physician**
NOTE: 1. Time spent completing the referral may not be claimed using complexity modifiers. \$32.43
2. May only be claimed when both the referring and consulting physician exchange communication using a secure email system that is in compliance with the CPSA guidelines on secure electronic communication and when the physician/clinic has submitted a Privacy Impact Assessment for this service acceptable to the Office of the Privacy Commissioner of Alberta.
3. May not be claimed for situations where the purpose of the communication is to:
a) arrange for laboratory or diagnostic investigations
b) discuss or inform of results of diagnostic investigations, or
c) arrange for an expedited consultation with the patient
4. Documentation of the request and advice given must be recorded in the patient record.
5. This service may not be claimed for transfer of care alone.

AMA Notes: 03.01R is intended to compensate physicians for the time and overhead costs associated with documenting an electronic referral.

Time spent documenting the referral may not be used in the total time claimed using complex modifiers. For example, the time spent reviewing and gathering chart information in preparation of the referral may be used in the calculation of complex modifiers but the time documenting the information on the electronic referral may not be included in claims for complex modifiers.

You may use 03.01R only when you have completed the referral using a secure electronic method such a secure electronic messaging, secure email or other secure electronic products that are accepted by the Office of the Information and Privacy Commissioner of Alberta (OIPC).

See the portion of the Billing Corner titled "Are you prepared for electronic communication?"

- 03.01O Physician to Physician **secure** E-Consultation, consultant \$76.27
- NOTE: 1. May only be claimed when both the ~~request and response~~ **referring and consulting physician exchange communication are sent by using a secure email system** ~~electronic means.~~ **that is in compliance with the CPSA guidelines on secure electronic communication and when the physician/clinic has submitted a Privacy Impact Assessment for this service acceptable to the Office of the Privacy Commissioner of Alberta.** ~~Please refer to the CPSA for email security guidelines. Physicians must be able to provide evidence of the proper use of email security guidelines.~~
2. This service is only eligible for payment if the consultant physician has provided an opinion/advice and/or recommendations for patient treatment and/or management within thirty (30) days from the date of the e-consultation request.
3. May only be claimed when initiated by the referring physician.
4. The consultant may not claim a major consultation, physician to physician phone call, or procedure for the same patient for the same condition within 24 hours of receiving the request for an e-consultation unless the patient was transferred from an outside facility and advice was given on management of that patient prior to transfer.
5. May only be claimed when the consultant has provided an opinion and recommendations for patient treatment as well as management after reviewing pertinent family/patient history, history of the presenting complaint as well as laboratory and other data where indicated. It is expected that the purpose of the communication will be to seek the advice of a physician more experienced in treating the particular problem in question, and that the referring physician intends to continue to care for the patient.
6. May not be claimed for situations where the purpose of the communication is to:
- arrange for an expedited consultation or procedure within 24 hours except when the conditions in note 4 are met
 - arrange for laboratory or diagnostic investigations
 - discuss or inform the referring physician of results of diagnostic investigations.
7. Documentation of the request and advice given must be recorded by the consultant in their patient records.
8. This service may not be claimed for transfer of care alone.

AMA Notes: 03.01O has been revised for consistency and to capture the necessary security details that are a part of electronic communications. This code is meant to compensate physicians for the time spent completing a consultation via electronic means. The intent is that the consultant would review the patients' referral letter and work up and make recommendations about treatment to the referring physician without actually having seen the patient.

You may use 03.01O only when you have completed the consultation using a secure electronic method such as secure electronic messaging, secure email or other secure electronic products that are accepted by the OIPC.

See the portion of the Billing Corner titled "Are you prepared for electronic communication?"

- 03.01S Physician to patient secure email communication \$15.88**
- NOTE:** 1. May only be claimed for medically necessary advice or follow up where the nature of the condition can safely be managed via secure email.
2. May only be claimed when the service is provided using a secure email system that is in compliance with the CPSA guidelines on secure electronic communication and when the physician/clinic has submitted a Privacy Impact Assessment for this service acceptable to the Office of the Privacy Commissioner of Alberta.
3. May only be claimed for those patients where an established physician-patient relationship exists and the physician has seen the patient in the previous 12 months.
4. Physicians and patients must have previously discussed and agreed to the limitations of health management using electronic means.
5. The secure email/messaging system must inform patients when the physician is unavailable.
6. May only be claimed once per week per patient per physician.
7. A maximum of seven 03.01S per calendar week per physician may be claimed.
8. A visit service may not be claimed if provided within 24 hours following the electronic communication.
9. Only one 03.05JR, 03.01S, or 03.01T may be claimed per patient per physician per week.
10. May not be claimed when the service is provided by a physician proxy.
11. Documentation of the service must be recorded in the patients' record.
12. May not be claimed for inpatients.

AMA Notes: Before you begin providing this service please see the portion of the Billing Corner titled "Are you prepared for electronic communication?"

03.01S may only be claimed once per patient per week regardless of the number of email exchanges occur. For example, your patient emails you about their minor condition that you have treated in the past, in order to get all the information necessary to make treatment decisions, you have a series of email exchanges with your patient. This series of exchanges may only be submitted as one claim for 03.01S.

You may only submit one claim per patient per week per physician for any combination of 03.01S, 03.05JR or 03.01T. For example, your patient emails you to get advice about their condition that you have treated in the past; you decide there isn't enough information in the email to proceed with advice so you phone the patient and follow up the phone call with an email. In this example, you may only submit one claim for either the phone call 03.05JR OR 03.01S but not both.

This service may only be claimed when a response prepared by the physician is provided to the patient. This code is not to be claimed for receiving an email and proceeding to call the patient in for a face-to-face visit.

03.01T	<p>Physician to patient secure videoconference \$15.88</p> <p>NOTE: 1. May only be claimed for medically necessary advice or follow up where the nature of the condition can safely be managed via secure videoconference.</p> <p>2. May only be claimed for those patients where an established physician-patient relationship exists and the physician has seen the patient in the previous 12 months.</p> <p>3. May only be claimed when the service is provided using a secure videoconference system that is in compliance with CPSA guidelines on secure electronic communication and when the physician/clinic has submitted a Privacy Impact Assessment for this service acceptable to the Office of the Privacy Commissioner of Alberta.</p> <p>4. May only be claimed once per week per patient per physician.</p> <p>5. A maximum of seven 03.01T per calendar week per physician may be claimed.</p> <p>6. A visit service may not be claimed if provided within 24 hours following the electronic communication.</p> <p>7. Only one 03.05JR, 03.01S, or 03.01T may be claimed per patient per physician per week.</p> <p>8. May not be claimed when the service is provided by a physician proxy.</p> <p>9. Documentation of the service must be recorded in the patients' record.</p> <p>10. May not be claimed for inpatients.</p>
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AMA Notes: Before you begin providing this service please see the portion of the Billing Corner titled "Are you prepared for electronic communication?"

You may only submit one claim per patient per week per physician for any combination of 03.01S, 03.05JR or 03.01T. This means that more than one physician can submit a claim for these services on the same patient per week but the same physician can only submit one claim for these services per week. For example, your patient emails you to get advice about their condition that you have treated in the past; you decide there isn't enough information in the email to proceed with advice so you respond to the email to set up a time to have videoconference with the patient. In this example, you may only submit one claim for the videoconference 03.01T. If you did not provide any advice in the email therefore the email code does not apply but you did complete the services via videoconference.

CHANGES TO PHYSICIAN TO PHYSICIAN VIDEOCONFERENCE CODES:

03.01LG	<p>Physician to physician or podiatric surgeon telephone or telehealth videoconference or secure videoconference consultation, referring physician, weekdays 0700 to 1700 hours \$32.90</p> <p>NOTE: Refer to notes following HSC 03.01LI.</p>
03.01LH	<p>Physician to physician or podiatric surgeon telephone or telehealth videoconference or secure videoconference consultation, referring physician, weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours \$38.32</p> <p>NOTE: Refer to notes following HSC 03.01LI.</p>

- 03.01LI Physician to physician or podiatric surgeon telephone or telehealth **videoconference or secure** videoconference consultation, referring physician, any day 2200 to 0700 hours **\$45.21**
NOTE: 1. HSCs 03.01LG, 03.01LH, 03.01LI may be claimed in addition to visits or other services provided on the same day by the same physician when criteria listed below are met.
2. May only be claimed when the consultant has provided an opinion and recommendations for patient treatment as well as management after reviewing pertinent family/patient history and history of the presenting complaint as well as discussion of the patient's condition and management after reviewing laboratory and other data where indicated. It is expected that the purpose of the call will be to seek the advice of a physician or podiatric surgeon more experienced in treating the particular problem in question, and that the referring physician intends to continue to care for the patient.
3. May not be claimed for situations where the purpose of the call is to:
- arrange for transfer of care that occurs within 24 hours unless the patient was transferred to an outside facility and advice was given on management of that patient prior to transfer
- arrange for an expedited consultation or procedure within 24 hours
- arrange for laboratory or diagnostic investigations
- discuss or inform the referring physician or podiatric surgeon of results of diagnostic investigations.
4. A maximum of two (any combination of HSC 03.01LG, 03.01LH, 03.01LI) claims may be claimed per patient, per physician, per day.
5. Documentation must be recorded by both the referring physician and the consultant in their respective records.
6. Telehealth videoconferences may only be claimed when all participants are participating in the videoconference from regional telehealth facilities.
7. **Claims for secure videoconference may only be claimed when the service is provided using a secure videoconference system that is in compliance with the CPSA guidelines on secure electronic communication and when the physician/clinic has submitted a Privacy Impact Assessment for this service accepted by the Office of the Privacy Commissioner of Alberta.**
- 03.01LJ Physician or podiatric surgeon to physician telephone or telehealth **videoconference or secure** videoconference consultation, consultant, weekdays 0700 to 1700 hours **\$77.35**
NOTE: Refer to notes following HSC 03.01LL.
- 03.01LK Physician or podiatric surgeon to physician telephone or telehealth **videoconference or secure** videoconference consultation, consultant, weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours **\$114.50**
NOTE: Refer to notes following HSC 03.01LL.

- 03.01LL Physician or podiatric surgeon to physician telephone or telehealth **videoconference** or **secure** videoconference consultation, consultant, any day 2200 to 0700 hours **\$135.13**
- NOTE: 1. HSCs 03.01LJ, 03.01LK, 03.01LL may only be claimed when initiated by the referring physician or podiatric surgeon.
2. The consultant may not claim a major consultation or procedure for the same patient for the same condition within 24 hours unless the patient was transferred from an outside facility and advice was given on management of that patient prior to transfer.
3. May only be claimed when the consultant has provided an opinion and recommendations for patient treatment as well as management after reviewing pertinent family/patient history and history of the presenting complaint as well as discussion of the patient's condition and management after reviewing laboratory and other data where indicated. It is expected that the purpose of the call will be to seek the advice of a physician more experienced in treating the particular problem in question, and that the referring physician or podiatric surgeon intends to continue to care for the patient.
4. 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
 - discuss or inform the referring physician or podiatric surgeon of results of diagnostic investigations.
5. A maximum of two (any combination of HSC 03.01LJ, 03.01LK, 03.01LL) claims may be claimed per patient, per physician, per day.
6. Documentation must be recorded by both the referring physician or the podiatric surgeon and the consultant in their respective records.
7. Telehealth videoconferences may only be claimed when all participants are participating in the videoconference from regional telehealth facilities.
- 7. Claims for secure videoconference may only be claimed when the service is provided using a secure videoconference system that is in compliance with the CPSA guidelines on secure electronic communication and when the physician/clinic has submitted a Privacy Impact Assessment for this service accepted by the Office of the Privacy Commissioner of Alberta**

AMA Notes: 03.01LL is intended to be performed in the exact same way as a phone call was prior to the change. The incorporation of videoconference technology is meant to enhance the service and allow communication via videoconferencing systems that is secure but not necessarily part of a telehealth videoconferencing service.

*This service **may not** be claimed for team conferences that occur via telephone.*

NEW FAMILY CONFERENCE CODE VIA TELEPHONE:

- 03.05JH** **Family conference via telephone, in regards to a community patient**
NOTE: 1. This service is to be claimed using the Personal Health Number of
the patient. \$15.88
- 2. May be claimed in situations where:**
- a) location or mobility factors of family members at the time of the call preclude in person meetings.**
 - b) communication about a patient's condition or to gather collateral information that is relative to patient management and care activities.**
- 3. May not be claimed for:**
- a) relaying results for lab or diagnostics.**
 - b) arranging follow up care.**
- 4. Documentation of the communication to be maintained in the patient record.**
- 5. May be claimed in the pre and post-operative periods.**

ARE YOU PREPARED FOR ELECTRONIC COMMUNICATION?

Identifying Secure Messaging and Videoconferencing Solutions

To leverage the electronic billing codes, it's mandatory that the systems in place in your clinic meet the required standards for data, privacy and security.

Regular e-mail (work e-mail, Gmail, Hotmail, Telus, Shaw, etc) is **not** secure for the purposes of exchanging health data.

Whether you have a messaging or videoconferencing system in place or are in the market for such a system, the following are privacy and security features that should be part of your solution:

- Secure data storage - data cannot be stored on phones, tablets, pcs, etc.
- Strong encryption for all in transit and at rest data - the solution must keep the data secure while it is being sent and while it is stored.
- Secure hosting facility for the messaging server
- Authenticated users – Only registered users have access to the system.
- Two factor authentication – User name/Password in addition to one other method of authentication
- Robust audit capabilities, including the logging of senders, receivers, timestamps, message receipt and message access
- Ability to thread related emails as one conversation
- Ability to store conversations/messages in the EMR patient chart
- Accessible via multiple platforms such as phone and tablet
- Privacy and security obligations addressed and approved by OIPC

If you do not currently have a solution in place we recommend contacting your EMR vendor. They may offer this functionality as part of their EMR software. Alternatively, AMA and Microquest are currently piloting a secure messaging solution. If you are interested in finding out more about the solution visit [AMA dr2dr Secure Messaging](#) .

Updating Privacy Agreements

As custodians of health data, physicians are responsible for ensuring the privacy, confidentiality and security of personal health information. A Privacy Impact Assessment (PIA) is a legislative requirement for all custodians.

Your PIA will need to be updated to reflect the use of a secure email or videoconferencing system in your office. If your PIA is current (less than 5 years old) an amendment may be all that is required. Your vendor or the AMA may have a template that you can customize and forward to the Office of the Privacy Commissioner of Alberta (OIPC).

You will also need an Information Manager Agreement (IMA) with your solution provider. This agreement addresses your privacy obligations when you are engaging with a third party to perform information technology services of any kind.

The AMA has created resource material to provide guidance on amending and creating agreements and determining if your PIA is compliant. Please refer to [What you need to know about privacy agreements](#) and [Are you compliant with the HIA?](#) .

If you are wondering if you have an accepted PIA, you can search the OIPC registry list which is hosted on the OIPC website <https://www.oipc.ab.ca/action-items/privacy-impact-assessments.aspx> under the A-Z Registry of PIAs Physician Listing.

If you have any questions regarding your privacy obligations, please contact Caroline.Garland@albertadoctors.org .

Getting Started

Not all physicians will offer electronic communications to their patients, if you do decide to offer these services, set yourself up for success:

- Investigate and choose a product
- Engage vendor and document implementation details (timelines, testing, training, user set up, ongoing assistance)
- Update your PIA and create an IMA if required. Your PIA amendment will address clinic policies and provide guidance on patient consent if required. Your IMA will detail the obligations of the vendor and a description of services provided.
- Create and communicate guidelines and expectations (response time, available, terms of use, etc) with clinic staff and patients (if required)
- Modify workflow to enable to new technology
 - Communicating changes to and obtaining consent from patients
 - Creating and updating processes to support electronic communication
 - Documenting electronic communication within the patient chart
 - Establishing processes for billing the new codes

Stay in touch with AMA, OIPC, CPSA and SOMB for policy and billing changes which could affect the way you provide or bill for the service.

If you have further questions please send an email to billingadvice@albertadoctors.org

SECTION OF CARDIOLOGY

- 49.95A Right cardiac catheterization with fluoroscopy
NOTE: May not be claimed in addition to HSCs 50.94D and 50.95A
Delete LVP50 rate and add LVP ADD rate
- 50.91A **Delete HSC**
Arterial line access.
- AMA Notes: Replace with 50.91D or 50.91E as appropriate*
- 50.91D **Radial arterial line access** \$53.65
NOTE: May not be claimed in addition to HSCs 48.98A, 48.98B, 51.59A, 51.59B, 51.59D, 51.59E and 51.59F.
- 50.91E **Femoral arterial line access** \$53.65
NOTE: May not be claimed in addition to HSCs 48.98A, 48.98B, 51.59A, 51.59B, 51.59D, 51.59E and 51.59F.
- 50.94D Introduction of central venous catheter, with or without ultrasound guidance
NOTE: May not be claimed in addition to HSC 49.95A.
Add BMIPRO
- 51.59D Percutaneous transluminal coronary angioplasty with associated diagnostic angiogram
NOTE: 1. May be claimed when the diagnostic angiogram is intended to determine appropriate treatment of the patient's coronary anatomy and is immediately followed by a coronary angioplasty by the same cardiologist.
2. Benefit includes other angiograms performed on the same date of service.
3. For each additional coronary vessel, refer to Price List.
4. Role modifier ASIC may be claimed for assistance at coronary angioplasty by a second interventional cardiologist.
5. May not be claimed in addition to HSCs 50.91D or 50.91E.
- 51.59E Percutaneous transluminal coronary angioplasty without associated angiogram
NOTE: 1. Patient will have had a previous angiogram to determine appropriate treatment.
2. May be claimed where the diagnosis has been determined and the patient's need for angioplasty has been established before the date of the procedure.
3. Coronary angiography may not be claimed on the same date of service by the same or different physician.
4. For each additional coronary vessel, refer to Price List.
5. Role modifier ASIC may be claimed for assistance at coronary angioplasty by a second interventional cardiologist.
6. May not be claimed in addition to HSCs 50.91D or 50.91E.

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

SECTION OF CRITICAL CARE MEDICINE
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- 46.91 Thoracentesis
NOTE: A repeat performed within 31 days is payable at a reduced rate. Refer to Price List.
Add BMIPRO
- 48.98A Selective angiography of aortocoronary vein bypass graft, per graft
NOTE: May not be claimed in addition to HSCs 50.91D or 50.91E.
- 48.98B Coronary angiography
NOTE: May not be claimed in addition to HSCs ~~50.91A~~ **50.91D or 50.91E.**
- 50.91A **Delete HSC**
Arterial line access.
- AMA Notes: Replace with 50.91D or 50.91E as appropriate.*
- 50.91D **Radial arterial line access** **\$53.65**
NOTE: May not be claimed in addition to HSCs 48.98A, 48.98B, 51.59A, 51.59B, 51.59D, 51.59E and 51.59F.
- 50.91E **Femoral arterial line access** **\$53.65**
NOTE: May not be claimed in addition to HSCs 48.98A, 48.98B, 51.59A, 51.59B, 51.59D, 51.59E and 51.59F.
- GR 13.3 Benefits may not be claimed for procedures that do not routinely require the services of a surgical assistant or a 2nd surgeon for a 2nd surgical team, unless supporting information detailing unusual circumstances satisfactory to the Minister is provided. Such procedures include but are not limited to the following list:
Delete HSC 50.91A
Add HSC 50.91D and 50.91E
- 50.93A Percutaneous insertion of catheter into blood vessel
NOTE: For hemodialysis of hemoperfusi
Add BMIPRO
- 50.94D Introduction of central venous catheter, with or without ultrasound guidance
NOTE: May not be claimed in addition to HSC 49.95A.
Add BMIPRO

SECTION OF DERMATOLOGY

- 03.03F Repeat office visit or scheduled outpatient visit in a regional facility, referred cases only
Delete skill DERM from price list.
- 98.12Q Removal of ~~(any method)~~ **any atypical or neoplastic lesion(s) – any method excluding cryotherapy for actinic keratoses**
Example: Multiple dysplastic naevi syndrome, **multiple basal and/or squamous cell carcinomas**
~~Multiple basal cell~~
NOTE: A maximum of five calls may be claimed.

SECTION OF DIAGNOSTIC IMAGING

- X 26 Mammography (one breast)
NOTE: May not be claimed in addition to HSC X105A.
- X 26A Mammoductography
NOTE: May not be claimed in addition to HSC X105A.
- X 26B Mammocystography
NOTE: May not be claimed in addition to HSC X105A.
- X 26C Percutaneous stereotactic core breast biopsy imaging guidance
NOTE: May not be claimed in addition to HSC X105A.
- X 27 Mammography (both breasts)
NOTE: May not be claimed in addition to HSC X105A.
- X 27E Screening mammography (age 75 years and over)
NOTE: 1. Benefits for X27C, X27D and X27E include patient education. A visit benefit may not be claimed in conjunction with these services by the radiologist performing the screening mammogram or by a different radiologist in conjunction with the same radiological examination.
2. Only one Screen Test or fee-for-service benefit may be claimed every calendar year.
3. X27C and X27E must be referred initially. Subsequent yearly referrals are not required. X27D does not require a referral.
4. X27C, X27D or X27E may not be claimed subsequent to X27 within the same calendar year.
5. Supplementary views refer to X27F.
6. X27C, X27D and X27E require submission of data to the Alberta Breast Cancer Screening Program through either the Alberta Society of Radiologists or the Alberta Cancer Board.
7. **X27C, X27D or X27E may not be claimed in addition to HSC X105A.**
- X 27F Diagnostic mammography, supplementary views
Taken within 90 days of X27C, X27D, X27E
NOTE: 1. May be self-referred.
2. May not be claimed in addition to HSCs X26, ~~X27~~ or X105A.
- X 27G Screening mammography for patients with the following conditions: implants, augmentation, mammoplasty, and when determined appropriate for screening by a radiologist and/or primary care physician, with the following conditions: post intervention (e.g. biopsy, excision, etc.) \$163.71
NOTE: May not be claimed in addition to HSC X105A.

X 105A	Multi-directional tomography, any area NOTE: May not be claimed in addition to HSCs X 26, X 26A, X 26B, X 26C, X 27, X 27C, X 27D, X 27E, X 27F or X 27G.	
X 49	Hip pinning Delete HSC	
46.91	Thoracentesis NOTE: A repeat performed within 31 days is payable at a reduced rate. Refer to Price List. Add BMIPRO	
50.93A	Percutaneous insertion of catheter into blood vessel NOTE: For hemodialysis or hemoperfusi Add BMIPRO	
51.59B	Percutaneous transluminal angioplasty, excluding coronary vessels NOTE: May not be claimed in addition to HSCs 50.91D or 50.91E.	
63.99D	Biliary drain exchange	\$87.79
66.82A	Retroperitoneal Mass Biopsy	\$117.31
GR 6.8.4	Where a procedure is performed under general anaesthesia, the following applies: e) GR 6.8.4 applies to the following HSCs: Add HSC 66.82A	

SECTION OF EMERGENCY MEDICINE

- 03.11A** **Visual assessment for patients presenting with acute visual disturbances or painful eye(s)** **\$96.92**
Note: 1. Assessment must include anterior and posterior chamber examinations, examination of retina, and may include pressure assessment if necessary.
2. May not be claimed for conditions or procedures related to obvious conjunctivitis, allergic conjunctival conditions, stye, eye lid conditions, foreign body or other similar conditions.
- 03.01LT** **Online medical control (OLMC) - Telephone calls from EMS practitioners on site to OLMC physicians on duty weekdays 0700 -1700 hours**
NOTE: Refer to the notes following HSC 03.01LV
- 03.01LU** **Online medical control (OLMC) - Telephone calls from EMS practitioners on site to OLMC physicians on duty weekdays 1700 -2200 hours, weekends and statutory holidays 0700 - 2200 hours** **\$34.85**
NOTE: Refer to the notes following HSC 03.01LV.
- 03.01LV** **Online medical control (OLMC) - Telephone calls from EMS practitioners on site to OLMC physicians on duty any day 2200 -0700 hours** **\$38.76**
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 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.
Add BMIPRO
- 46.91 Thoracentesis
NOTE: A repeat performed within 31 days is payable at a reduced rate. Refer to Price List.
Add BMIPRO
- 50.94D Introduction of central venous catheter, with or without ultrasound guidance
NOTE: May not be claimed in addition to HSC 49.95A.
Add BMIPRO
- 66.91A Paracentesis
Add BMIPRO

SECTION OF GASTROENTEROLOGY

- 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 **\$46.99**
- NOTE: 1. May only be claimed in addition to HSC 03.03F when the 03.03F exceeds 30 minutes.
2. May only be claimed by pediatrics (including subspecialties) and clinical immunology and allergy for patients 18 years of age and under, or by cardiology, endocrinology/metabolism, **gastroenterology**, infectious diseases, internal medicine, hematology, medical genetics, physiatry, **respiratory medicine**, rheumatology, urology and vascular surgery (no age restriction).
- Add skill GAST to price list**

SECTION OF GENERALISTS IN MENTAL HEALTH

- 08.11B Evidence from a psychiatrist at a Review Panel on behalf of a specific patient, as required under section 37(3) of the Mental Health Act, per 15 minutes or portion thereof
NOTE: 1. This service is to be claimed using the Personal Health Number of the patient.
2. **May only be claimed by a psychiatrist or a generalist in mental health.**
- 08.19G 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.
NOTE: 1. May be claimed:
- if the intent of the session is the therapy of one individual patient, whether or not more than one person is involved in the session.
- when a physician assessment has established (during the same or previous visit) that the patient is suffering from a psychiatric disorder.
2. For treatment of non-psychiatric disorders, the appropriate office visit health service code should be claimed.
Delete skill GNMH from price list.

AMA Notes: GNMH physicians can no longer bill 08.19G using the GNMH skill code, they should now bill 08.19GA for direct psychotherapy when billing for services as GNMH.

- 08.19GA Direct contact with a patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or psychiatric counseling, per 15 minutes or major portion thereof **\$43.67**
NOTE: 1. May only be claimed by a psychiatrist (PSYC), **a generalist in Mental Health (GNMH)** or by a specialist in Mental Health (SPMH) if the intent of the session is the therapy of one individual patient, whether or not more than one person is involved in the session. 2. May be claimed for both referred and non-referred patients with psychiatric disorders.
Add skill GNMH to price list

SECTION OF GENERAL PRACTICE

- 13.99BC Pelvic examination using a speculum requiring swab(s) and/or sample(s) collection; and/or Periodic Papanicolaou Smear
NOTE: 1. Two Papanicolaou smears may be claimed per patient, per physician, per year (April 1 of one year to March 31 of the following year). Additional claims may be submitted with supporting information.
2. May be claimed with a visit or consultation.
3. **May not be claimed at the same encounter as HSC 13.99BD.**
- 13.99BD **Anal Papanicolaou Smear** **\$16.92**
NOTE: 1. **Two Anal Papanicolaou smears may be claimed per patient, per physician, per year (April 1 of one year to March 31 of the following year). Additional claims may be submitted with supporting information.**
2. **May be claimed with a visit or consultation.**
3. **May not be claimed at the same encounter as HSC 13.99BC.**
- 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, **hospice patient**, AACC or UCC patient
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.
6. May be claimed in addition to visits or other services provided on the same day, by the same physician.

SUBD SUBDIVISION - (Explicit) - This modifier type is used with visit health service codes to indicate during which time period the service recipient/service provider encounter took place. These modifiers are applicable during the evening on weekdays, during the day and evening on weekends and statutory holidays, and during the night on any day. A fee is added to the base rate as indicated by the modifier.

For home visits **and hospice visits**, the SUBD modifier should be claimed based on the time at which the encounter commences and the physician responds on an unscheduled basis within a 24 hour period from the time of the call.

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

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

- 03.01NI Patient care advice to paramedic - pre hospital patch, assisted living/ designated assisted living and lodge staff, active treatment facility worker for hospital in-patient, long term care worker for patients in a long term care facility, nurse practitioner, **hospice worker**, ~~or~~ home care worker, **or public health nurse** any day 2200 to 0700 hours, provided via telephone or other telecommunication methods, in relation to the care and treatment of a patient
- NOTE: 1. Active treatment facility worker may include registered: nurse, licensed practical nurse, occupational therapist, physiotherapist, speech language pathologist, social worker, pharmacist, psychologist, recreational therapist or respiratory therapist.
2. Long term care worker/**hospice worker** may include registered: nurse, licensed practical nurse, occupational therapist, physiotherapist, speech language pathologist, social worker, pharmacist, psychologist or recreational therapist.
3. Advice to nurse practitioners may only be claimed if the nurse practitioner is in independent practice or working at a nursing station where no physician is present. **Advice to a public health nurse may only be claimed if the public health nurse is employed by AHS and working in an AHS health unit.**
4. In the case of long term care or active treatment facility worker, claims may only be submitted when the physician is outside the facility where the patient is located.
5. May be claimed for advice given to **hospice worker**, home care worker **or public health nurse** in person as well as advice by telephone or other telecommunication methods.
6. HSCs 03.01NG, 03.01NH and 03.01NI are to be claimed using the Personal Health Number of the patient.
7. May only be claimed when the call is initiated by the long term care worker, assisted living/ designated assisted living or lodge staff member, active treatment facility worker, home care worker, nurse practitioner, **hospice worker**, **public health nurse** or paramedic.
8. In the case of a long term care **or hospice** patient the call may be initiated by the physician if it is in response to receipt of diagnostic or other information that would affect the patient's treatment plan.
9. May be claimed in addition to visits or other services provided on the same day, by the same physician.
10. A maximum of two (any combination of HSC 03.01NG, 03.01NH, 03.01NI) claims may be made per patient, per physician, per day.
11. Documentation of the communication must be recorded in their respective records.

AMA Notes: A reminder that in order to claim the SUBD modifier on any home visit, a special call for attendance on the patient's behalf must be made and the physician responds within 24 hours of the call. If both criteria are not met, a SUBD modifier may not be claimed.

- 03.03Q Home visit - repeat visit same day
Include SUBD Modifiers on price list.

- 03.04K Comprehensive geriatric assessment, first full 90 minutes
- NOTE: 1. If the assessment is less than 90 minutes, then HSC 03.04A or 03.08A should be claimed.
2. May only be claimed when performed in an AHS regional facility **or AHS/Contracted partner run geriatric program(s) or community clinic where a PCN multi-disciplinary team is contributing to the assessment.**
 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 only be claimed once per patient per year.
 6. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List, to a maximum of 7 calls.
 7. 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, balance and assessment of senior falls.
 - 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.
 8. Evidence that all components in note 7 were completed must be documented in the patient's records. This includes physician notes and copies of the MMSE and GDS.

AMA Notes: This amendment will allow the service to be claimed in locations outside of Alberta Health Services (AHS) facilities where AHS has contracted with the clinic to perform comprehensive geriatric assessments. It also allows Primary Care Networks (PCN) that are enabled to complete all aspects of the criteria described in the code but note that the physician must be in attendance supervising or witnessing the physiotherapists or other providers assessments. Documentation and findings that all criteria have been met must be recorded in the patient's record.

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

\$84.61

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

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

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

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

AMA Notes: 03.03NA and 03.03NB codes are billable for those patients that do not reside in AHS long term care, or their own home that is a single family residence. For example: an apartment (multiple units), where the physician enters into each living unit to complete the Home Visit service.

03.03NA is to be billed for the first patient seen at the complex; the second and subsequent patient in the same complex is to be billed using 03.03NB.

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

\$84.61

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

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

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

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

AMA Notes: 03.03NA and 03.03NB codes are billable for those patients that do not reside in AHS long term care, or their own home that is a single family residence. For example: an apartment (multiple units), where the physician enters into each living unit to complete the Home Visit service.

03.03NB is to be used for the second patient at the same complex, not necessarily residing in the same living unit as the first patient.

95.35A Delete HSC

Excision of deep fascia of calf in association with varicose vein operation, additional benefit

NOTE: May only be claimed with 50.4F.

SECTION OF GENERAL SURGERY

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

<p><i>AMA Notes: This change reduces the number of 03.05Bs that can be claimed. A non-surgical trauma patient requiring a stay of nine days may have a billing as follows:</i></p>
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<p><i>Day one: 13.99GA</i></p>

<p><i>Day two to seven: 03.05B, 6 calls</i></p>

<p><i>Day eight to nine: 03.03D, 2 calls</i></p>
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- 19.7B Parathyroidectomy with mediastinal exploration
NOTE: May not be claimed in addition to HSC 20.73.
- 20.73 Total excision of thymus
NOTE: May not be claimed in addition to HSC 19.7 B.
- 55.3 Pyloromyotomy – Ramstedt
Delete LVP75 rate and add LVP50 rate
- 56.2 Gastroenterostomy (without gastrectomy)
 NOTE: May not be claimed with HSCs 64.3, 64.43A, 64.49A or 64.7.
- 57.42A Small bowel resection
 NOTE: 1. May only be claimed with HSC 57.59A when two anastomoses are performed.
 2. May only be claimed with HSC 60.52B when two discontinuous areas are resected and two anastomoses are performed.
3. May not be claimed in addition to HSC 63.12B.

- 57.59A Partial or segmental colectomy
NOTE: 1. Benefit includes right hemicolectomy, left hemicolectomy, sigmoid colectomy or extended right hemicolectomy.
2. More than one call may be claimed if two or more anastomoses are performed.
3. May only be claimed with HSC 60.52B when two discontinuous areas are resected and two anastomoses are performed.
4. May not be claimed with HSC 60.52A or **63.12B**.
- 58.73 Other suture of small intestine, except duodenum
NOTE: 1. May not be claimed for incidental bowel perforations.
2. May not be claimed in addition to HSC 63.12B.
- 58.75A Suture of large or small intestine
NOTE: 1. May not be claimed for incidental bowel perforations.
2. May not be claimed in addition to HSC 63.12B.
- 62.12C Partial resection of liver
NOTE: 1. May not be claimed for wedge biopsy.
2. May not be claimed in addition to HSC 62.2B or 63.12B.
- 62.2 **Delete HSC**
Lobectomy of liver
- 62.2B Lobectomy of liver – 4 or more hepatic segments \$2515.38**
NOTE: May not be claimed in addition to HSC 62.12C or 63.12B.
- 63.12A ~~Total~~ **Open surgical** cholecystectomy
NOTE: 1. **May not be claimed for laparoscopic cholecystectomy.**
- 63.12B Cholecystectomy with closure of fistula to duodenum or colon
NOTE: **May not be claimed in addition to HSCs 57.42A, 57.59A, 58.73, 58.75A, 62.12C or 62.2B.**
- 63.14 Laparoscopic cholecystectomy
NOTE: **May not be claimed for open surgical cholecystectomy.**
- 63.26 **Delete HSC**
Anastomosis of common bile duct to intestine
NOTE: Refer to the note following HSC 63.27.
- 63.27 Anastomosis of hepatic duct to gastrointestinal tract
NOTE: HSCs 63.22, ~~63.26~~ and 63.27 may not be claimed in addition to HSCs **63.41, 63.69A, 64.3, 64.43A, 64.49A** or 64.7.

- 63.69A **Resection and reconstruction of common bile duct including secondary plastic repair and all anastomoses**
NOTE: May not be claimed in addition to HSCs 52.2, 57.7, 62.12C or 62.2B.
- 63.95A **Delete HSC**
63.95A Interoperative choledochoscopy
- 64.3 Internal drainage of pancreatic cyst
Pancreatico-cystoenterostomy
NOTE: May not be claimed with HSCs 56.2, 63.22, ~~63.26~~, 63.27 and 64.7.
- 64.43A Pancreatectomy 95% resection
NOTE: 1. May be claimed in addition to HSC 66.83.
2. May not be claimed with HSCs 56.2, 63.22, ~~63.26~~, 63.27 and 64.7.
- 64.49 **Delete HSC**
Other partial pancreatectomy
NOTE: 1. May be claimed in addition to HSC 66.83.
2. May not be claimed with HSCs 56.2, 63.22, 63.26, 63.27 and 64.7.
- 64.49A **Other partial pancreatectomy - with or without splenectomy \$1569.24**
NOTE: 1. May be claimed in addition to HSC 66.83.
2. May not be claimed with HSCs 56.2, 63.22, 63.27 and 64.7.
- 64.7 Anastomosis of pancreas (duct)
Pancreatico-enterostomy
NOTE: May not be claimed with HSCs 56.2, 63.22, ~~63.26~~, 63.27, 64.3, 64.43A or 64.49A.
- 66.19E **Intraperitoneal Chemotherapy \$500.00**
- 66.51A **Complete Post-operative closure or delayed primary closure abdominal wall**

AMA Notes: May not be claimed at the same encounter as the primary procedure that created the opening.
- 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 83.2B, which may be claimed at 100%.
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, 64.49A.

- 97.27B Segmental resection, with ~~formal axillary node dissection and/or~~ sentinel node biopsy, ~~with or without removal of pectoral muscles~~
NOTE: When claimed in addition to HSC 52.42, the benefit will be paid at LVP50.
- GR 6.9.7 g) Procedures in different groups in the following table may be claimed at each when performed at the same operative encounter. For example, procedures listed in group B may be claimed at 100% when performed at the same operative encounter as procedures listed in group A. Two procedures from the same group will continue to be paid at 100% and 75% for second and subsequent procedures. This does not apply to anesthetic services; refer to GR 12.4.
Delete HSC 63.26 from Group C
Add 62.2B and 64.49A to Group C

SECTION OF INTERNAL MEDICINE

- 46.91 Thoracentesis
NOTE: A repeat performed within 31 days is payable at a reduced rate. Refer to Price List.
Add BMIPRO
- 50.94D Introduction of central venous catheter, with or without ultrasound guidance
NOTE: May not be claimed in addition to HSC 49.95A.
Add BMIPRO

SECTION OF OBSTETRICS AND GYNECOLOGY

- 13.99BC Pelvic examination using a speculum requiring swab(s) and/or sample(s) collection; and/or Periodic Papanicolaou Smear
NOTE: 1. Two Papanicolaou smears may be claimed per patient, per physician, per year (April 1 of one year to March 31 of the following year). Additional claims may be submitted with supporting information.
2. May be claimed with a visit or consultation.
3. **May not be claimed at the same encounter as HSC 13.99BD.**
- 13.99BD Anal Papanicolaou Smear **\$16.92**
NOTE: 1. Two Anal Papanicolaou smears may be claimed per patient, per physician, per year (April 1 of one year to March 31 of the following year). Additional claims may be submitted with supporting information.
2. May be claimed with a visit or consultation.
3. **May not be claimed at the same encounter as HSC 13.99BC.**

SECTION OF OPHTHALMOLOGY

- 25.69A Therapeutic corneal cross-linking examination for progressing cases of keratoconus or pellucid marginal degeneration, per eye \$1263.76
NOTE: 1. May not be claimed for services provided in association or in relation to refractive surgery either 2 years preceding refractive surgery or 2 years following refractive surgery. Patient must have a greater than 1 Dioptre change in refractive astigmatism and a greater than one line loss of corrected acuity documented over a minimum of three examinations (one baseline and two follow ups).
2. May only be claimed for epithelium-off procedures.
- 29.0 B Orbitotomy for decompression
NOTE: A second, ~~or~~ third **or fourth** call may be claimed at the rate specified on the Price List.

SECTION OF OTOLARYNGOLOGY

98.6Q **Delete HSC**
 Columella lengthening

SECTION OF PHYSICAL MEDICINE AND REHABILITATION
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- 95.94C** **Ultrasound guidance during injection of soft tissue (trigger point), peripheral nerve, muscle, tendon, ligament, bursa or joint, additional benefit \$49.19**
NOTE: 1. May only be claimed by Physical Medicine and Rehabilitation.
2. May only be claimed with HSCs 13.59H, 13.59J, 16.89B, 16.89D, 16.99A, 17.71A, 92.78C, 93.91A, 93.91B, 95.93 and 95.96A.

AMA Notes: This code is only billable in addition to those services listed in Note 2. It may not be claimed when using hand held ultrasound machines. It may only be claimed by Physical Medicine specialists that have completed training in the area of joint injections or American Registry for Diagnostic Medical Sonography (ARDMS) qualified physicians. An example of a service may look like:

<i>encounter 1</i>	<i>93.91A joint aspiration, hip</i>
	<i>95.94c ultrasound guidance</i>

- GR 6.5** **NON-INVASIVE DIAGNOSTIC PROCEDURES IN HOSPITAL, AACC OR UCC**
Benefits for non-invasive diagnostic procedures including HSCs in Section E (Laboratory and Pathology) and X (Diagnostic Radiology) performed for a hospital inpatient, registered outpatient or AACC or UCC patient are not payable under the Schedule. Payment for these services is the responsibility of the hospital/Regional Health Authority. This applies to both the technical and professional components. Such procedures include but are not limited to the following list.
Add HSC 95.94C

SECTION OF RESPIRATORY MEDICINE
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- 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 **\$45.95**
NOTE: 1. May only be claimed in addition to HSC 03.03F when the 03.03F exceeds 30 minutes.
2. May only be claimed by pediatrics (including subspecialties) and clinical immunology and allergy for patients 18 years of age and under, or by cardiology, endocrinology/metabolism, **gastroenterology**, infectious diseases, internal medicine, hematology, medical genetics, physiatry, **respiratory medicine**, rheumatology, urology and vascular surgery (no age restriction).
Add skill RSMD to price list.
- 03.08I Prolonged endocrinology/ metabolism, gastroenterology, hematology, infectious diseases, internal medicine, nephrology, physiatry, neurology, **respiratory medicine** or rheumatology consultation or visit, full 15 minutes or major portion thereof for the first call when only one call is claimed **\$46.66**
NOTE: May only be claimed in addition to HSCs 03.04A, 03.04C, 03.07B and 03.08A when these services exceed 30 minutes.
- 46.91 Thoracentesis
NOTE: A repeat performed within 31 days is payable at a reduced rate. Refer to Price List.
Add BMIPRO

SECTION OF UROLOGY		
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76.39A	Repair of penile fracture	\$339.56
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SECTION OF VASCULAR SURGERY

51.59B Percutaneous transluminal angioplasty, excluding coronary vessels
NOTE: May not be claimed in addition to HSCs 50.91D or 50.91E.