Please share this information 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 December 1, 2015

CHANGES TO GENERAL RULES
(NOTE: Wording in bold indicates changes)

GR 1.30  “Calendar week” means a period of seven consecutive days beginning with Sunday and ending with Saturday.

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:
Remove HSC 47.02C from the list as it was inadvertently added.

AMA NOTES: this code was added April 1, 2015 in error; this error did not result in the rejection of any claims.
GR 4.4.8 CLAIMS REQUIRING REFERRING PRACTITIONER NUMBER

When a claim is submitted for the following HSCs, the referring practitioner field must be completed with a valid referring practitioner number. HSCs in the following list marked with an asterisk(*) cannot be self-referred. Self-referred means the physician is providing the diagnostic service and treating the patient.

HSCs in Section E (Lab and Pathology) and X (Diagnostic Radiology) require a valid referring practitioner number with the following exceptions:

- HSC X27D does not require a referral and HSC X27F may be self-referred.
- HSC 03.03D requires a valid referring physician, chiropractor, midwife, podiatrist, dentist, optometrist, physical therapist or nurse practitioner number when it is a visit to a referred patient.

Add HSCs 09.02E, 09.13G and 09.13H as they were inadvertently removed.

AMA NOTES: These codes were removed April 1, 2015 in error; this error did not result in the rejection of any claims.

GR 6.9.7 g) The section on multiple procedures does not apply where the lesser or secondary procedure is:

- 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.

Under Group C, delete HSC 59.1A and add HSC 59.0A.

AMA NOTES: 59.1A Appendectomy will be deleted and replaced with 59.0A

59.0A Appendectomy

59.0A Appendectomy with or without abscess

NOTE: May not be claimed for incidental appendectomies.

DELETE

59.1 Drainage of appendiceal abscess

59.1A Appendectomy with or without abscess

NOTE: May not be claimed for incidental appendectomies.
HEALTH SERVICE CODE CHANGES
(NOTE: Wording in bold indicates changes)

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. Include examination of each organ system of the body, except in psychiatry, dermatology and the surgical specialties. “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. What is customary and usual may be judged by peer review.
3. Benefit includes the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient.

03.04Q Post surgical cancer surveillance examination

NOTE:
1. Intended for patients requiring scheduled comprehensive evaluations relevant to the specific type of cancer adhering to protocols as defined by the facility, program or surgeon from which the patient was discharged.
2. Comprehensive evaluations must adhere to protocols as defined by the facility, program or surgeon from which the patient was discharged.
3. The discharge letter that states the protocols must be forwarded to Alberta Health for claim processing for each claim submitted. The letter must indicate:
   a. Date of surgery
   b. Schedule of required comprehensive visits and other diagnostic testing
   c. Duration of required follow-ups (i.e. two years from date of surgery)
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

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.

AMA NOTES: If you have received refused claims due to other services being provided on the same date of service by the same physician, you may resubmit your claims. Before resubmitting the claims please find your statement of assessment from Alberta Health. Determine if your claims were RFSE or APLY.

For claims that were RFSE: you must delete the original claim from your billing software and generate a new claim for the patient for the service.

For claims that were APLY: you do not need to change anything on your claim. Alberta Health will reassess claims that were APLY.

For refused claims that are out of date, the AMA and AH will publish information about resubmissions when available.
03.05JQ  Family conference with relative(s) via telephone in connection with the management of a patient with a psychiatric disorder

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

**AMA NOTES:** If you have received refused claims due to other services being provided on the same date of service by the same physician, you may resubmit your claims. Before resubmitting the claims please find your statement of assessment from Alberta Health. Determine if your claims were RFSE or APLY.

For claims that were RFSE: you must delete the original claim from your billing software and generate a new claim for the patient for the service.

For claims that were APLY: you do not need to change anything on your claim. Alberta Health will reassess claims that were APLY.

For refused claims that are out of date, the AMA and AH will publish information about resubmissions when available.
O3.05JR  Physician telephone call directly to patient, to discuss patient management/diagnostic test results

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 only be claimed when communication is with provided by a proxy for the physician.
4. Documentation of the communication to be recorded in the patient record.
5. May be claimed in addition to visits or other services provided on the same day, by the same physician.

AMA NOTES: If you have received refused claims due to other services being provided on the same date of service by the same physician, you may resubmit your claims. Before resubmitting the claims please find your statement assessment from Alberta Health. Determine if your claims were RFSE or APLY.

For claims that were RFSE: you must delete the original claim from your billing software and generate a new claim for the patient for the service.

For claims that were APLY: you do not need to change anything on your claim. Alberta Health will reassess claims that were APLY.

For refused claims that are out of date, the AMA and AH will publish information about resubmissions when available.
03.05R Special callback to hospital inpatient, weekends and statutory holidays 0700-2200 hours

NOTE:
1. May only be claimed when a special call for attendance is made on the patient's behalf.
2. Benefits are payable based on the time at which the encounter commences.
3. The physician responds to such a call from outside the hospital, on an unscheduled basis.
4. The patient is attended on a priority basis.
5. There is direct attendance by the physician.
6. Second or subsequent patients seen during the same callback are not eligible for benefits under HSCs 03.05N, 03.05P, 03.05QA, 03.05QB or 03.05R but may be claimed using HSC 03.03AR.
7. May not be claimed in association with any HSC except HSC 03.01AA or 03.03DF. Refer to GR 15.8.
8. Special callback benefits (03.05N, 03.05P, 03.05QA, 03.05QB or 03.05R) should be claimed in addition to HSC 03.03DF.

13.99BC Pelvic examination using a speculum requiring swab(s) and/or sample(s) collection; and/or includes 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.

22.51A Functional blepharoplasty - upper eyelid - without cosmetic intent

NOTE: May only be claimed for patients where at least half the pupil is covered by the skin of the upper eyelids. Sufficient evidence to support this must be documented in the patient record.

43.65C Secondary larynx tracheoesophageal puncture and valve insertion

NOTE: May be claimed 30 days or more after laryngectomy.
DELETE

59.1  Drainage of appendiceal abscess
59.1 A Appendectomy with or without abscess
    NOTE: May not be claimed for incidental appendectomies.

   **AMA NOTES: 59.1A Appendectomy will be deleted and replaced with 59.0 A**

59.0A  Appendectomy
59.0A Appendectomy with or without abscess
    NOTE: May not be claimed for incidental appendectomies.

   **AMA NOTES: This is a new code that will replace 59.1A which is being deleted. For dates of service December 1 onwards, use 59.0A for appendectomy claims.**

65.01A  Repair of inguinal hernia  – incarcerated, obstructed or strangulated with or without incarceration, obstruction or strangulation

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