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 October 1, 2016
GR 6.8.4 Where a procedure is performed under general anesthesia, the following applies:

1. If the procedure is the only procedure performed at that time, a benefit of $134.85 may be claimed.
2. If another procedure is also performed at the same encounter and the listed benefit payable in respect of it under the Schedule is greater than $134.85 the physician is entitled to receive that listed benefit plus a percentage of the listed benefit for the lesser procedure(s) calculated in accordance with this Schedule. The $134.85 minimum benefit does not apply to the lesser procedures.
3. If multiple procedures are performed at the same encounter and the listed benefit payable in respect of each of them under the Schedule is less than $134.85, the physician is entitled to receive a benefit of $134.85 in respect of the greater procedure plus a benefit in respect of each of the lesser procedures that is a percentage of the listed benefit and calculated in accordance with this schedule. The $134.85 minimum benefit does not apply to the lesser procedures.
4. If multiple procedures are performed at the same encounter and only one of them appears under GR 6.8.4 (e), the physician is entitled to receive a benefit of $134.85 in respect of that procedure plus a benefit in respect of the other procedures that is a percentage of the listed benefit and calculated in accordance with this schedule.
5. GR 6.8.4 applies to the following HSCs:

ADD HSCs 11.71A, 13.59O, 21.69C, 46.09B, 92.70, 92.71, 92.72, 92.74, 92.75, 92.76 and 92.78C

DELETE HSC 21.31A.
03.01O Physician to Physician secure E-Consultation, consultant $76.27

NOTE: 1. May only be claimed when both the referring and consulting physician exchange communication using a secure electronic communication 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.
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: a. arrange for an expedited consultation or procedure within 24 hours except when the conditions in note 4 are met b. arrange for laboratory or diagnostic investigations c. 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.
03.01R  Physician to Physician secure E-Consultation, referring physician  $32.43
NOTE: 1. Time spent completing the referral may not be claimed using complexity modifiers.
2. May only be claimed when both the referring and consulting physician exchange communication using a secure email system electronic communication 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.

03.01S  Physician to patient secure email electronic 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 electronic communication 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. HSC 03.01S is not payable in the same calendar week as 03.05JR or 03.01T by the same physician for the same patient.
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.
03.01T  Physician to patient secure videoconference  $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 videoconference.
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.
3. 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 acceptable to the Office of the Privacy Commissioner of Alberta.
4. May only be claimed once per week per patient per physician.
5. A maximum of seven 03.01T per calendar week per physician may be claimed.
6. A visit service may not be claimed if provided within 24 hours following the electronic communication.
7. Only one 03.05JR, 03.01S, or 03.01T may be claimed per patient per physician per week. HSC 03.01T is not payable in the same calendar week as 03.05JR or 03.01S by the same physician for the same patient.
8. May not be claimed when the service is provided by a physician proxy.
9. Documentation of the service must be recorded in the patients’ record.
10. May not be claimed for inpatients.

03.05JA  Formal, scheduled, multiple health discipline team conference, full 15 minutes or major portion thereof for the first call when only one call is claimed With para-medical personnel regarding the provision of health care where social and other issues are involved $41.99
NOTE: 1. May be claimed when the conference involves the physician and one or more allied health professionals.
2. May be claimed by more than one physician where circumstances warrant (text will be required).

03.05JR  Physician telephone call directly to patient, to discuss patient management/diagnostic test results $15.88
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 only be claimed when communication is provided by 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.
6. Neither HSCs 03.01S or 03.01T are payable if HSC 03.05JR is claimed in the same calendar week by the same physician.
13.99E  Resuscitation, full 60 minutes or a portion thereof for the first call when only one call is claimed  $386.03
NOTE: 1. Resuscitation is defined as the emergency treatment of an unstable patient whose condition may result in imminent mortality without such intervention.
2. May be claimed when this service follows a consultation or hospital visit earlier in the same day as defined under GR 1.19.
3. After the first full 60 minutes has elapsed, each subsequent 15 minutes or portion thereof is payable at the rate specified in the Price List.
4. When the condition of the patient is such that further care is provided, either before or after the patient is resuscitated, at a level consistent with the description of HSC 13.99H, 13.99HA, 13.99J, 13.99K, 13.99KA or 13.99KB, time spent providing that care may be claimed using these HSCs.
Concurrent claims for overlapping time for the same or different patients may not be claimed.
5. If two claims for HSC 13.99E at different encounters are submitted by the same or different physician, text is required.

13.99M  Donor maintenance during cadaveric organ harvesting, first full 35 minutes
NOTE: Each subsequent full 5 minutes may be claimed at the rate specified on the Price List.

AMA NOTES: This is a rate change, the ANE rate is changed to $153.65 and the 2ANES rate is equal to 2ANES.

36.99F  Surgical assistant for dental surgery performed by oral surgeons
147.31 BMI BMIPRO Y Increase By 25% R

CALL M15
CALL H1M15

AMA NOTES: this change aligns the payment with the surgical assist payment model where the first unit is one hour and the second and subsequent units are 15 minutes.
57.13A Bipolar electrocoagulation/heater probe hemostasis or endoclip placement or argon plasma coagulation for bleeding lesions of the colon following an initial procedure at a separate encounter, additional benefit $136.79

NOTE: 1. May only be claimed in addition to HSCs 01.16B, 01.22, 01.22A, 01.22B, 01.22C, 01.24B, 01.24BA and 01.24BB.
2. May only be claimed in situations where the patient has post-polypectomy bleeding following an initial procedure and must undergo where a repeat procedure to manage post polypectomy bleeding is required following the initial procedure.
3. May not be claimed for services provided at the same encounter as the initial polypectomy.

AMA NOTES: This change clarifies that the 57.13A is intended for repeat procedures where post polypectomy bleeding requires a repeat procedure.

57.21A Polypectomy of large intestine, additional benefit $85.49

NOTE: 1. May only be claimed with HSCs 01.16B, 01.16C, 01.22, 01.22A, 01.22B, and 01.22C, 01.24BA and 01.24BB and when the removal of a colonic mucosal lesion is performed using a polypectomy snare (with or without electrocautery) or a hot biopsy forceps.
2. May not be claimed when a regular biopsy forceps is used to remove a diminutive polyp without electrocautery, even if multiple passes are required.
3. Benefit includes placement of clips at the time of polypectomy.
4. Each additional polyp may be claimed at the rate specified on the Price List; a maximum benefit of six calls applies.

57.21C Removal of sessile polyp, additional benefit $175.00

NOTE: 1. May only be claimed for polyps greater than 2 cms in size requiring submucosal injection and piecemeal resection.
2. May only be claimed in addition to HSCs 01.22, 01.22A, 01.22B, 01.22C, 01.24B, 01.24BA and 01.24BB.
3. May be claimed in addition to HSC 57.21A if polyps are removed from different sites.
4. May not be claimed for pedunculated polyps.
5. Benefit includes placement of clips at the time of polypectomy.
6. A maximum of two calls applies.

63.41 Incision of the common duct $1150.78

Note: May not be claimed in addition to HSC 63.27
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
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<tbody>
<tr>
<td>63.69A</td>
<td>Resection and reconstruction of common bile duct including secondary plastic repair and all anastomoses</td>
<td>$2587.33</td>
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<td>NOTE: May not be claimed in addition to HSCs 52.2, 57.7, 62.12C, or 62.2 B or 63.27.</td>
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<tr>
<td>98.04A</td>
<td>Incision with removal of foreign body of skin and subcutaneous tissue <strong>under anaesthesia</strong></td>
<td>$43.73</td>
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<tr>
<td>98.04B</td>
<td>Incision with removal of foreign body of skin and subcutaneous tissue <strong>without anaesthesia</strong></td>
<td>$23.19</td>
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