Billing Corner

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Billing Corner is also available on the Alberta Medical Association website
http://bit.ly/1oNj9im

April 2014

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.albertadoctors.org/services/physicians/compensation/billing-help/somb#Billing

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, 2014

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HIGHLIGHTS

GR 2.3.6 When billing time based services, including modifiers, the physician must document the time spent providing time based services for each day of service (as defined in GR 1.19). The record must be available upon request and should be kept in chronological order, for each day. The total time claimed for time based services in a single day cannot exceed the total time spent delivering patient care activities in relation to an insured service. Claims for services that are described as cumulative time, major portion thereof or portion thereof may continue to be submitted in accordance to GR's 2.3.2, 2.3.4 and 2.3.5.

AMA NOTES:

- *This new rule requires physicians to record the time they started providing patient management activities and the time they were finished for **only** those days where time based health service codes or modifiers are claimed.*
- *The record of these entries must be kept in sequential order by day and in one place. The total time recorded for each day should **not** include time spent on activities that are not related to patient management such as mealtime/breaks, travel time, etc.*
- *This information will remain in the physician's possession and will not be sent to AH unless requested by AH in the event of an audit.*

FAQ's:

How will I record my time?
Although each physician will have to find a method that works best for them, some suggestions are:

- *use a coiled notebook where pages cannot be added.*
- *download a time management app that can produce either printable records or downloadable records.*
- *use your EMR. Some physicians have reported creating a fictitious patient (first name "start", last name "endtime") that they use to date stamp the start and end times.*

The AMA is suggesting that physicians begin to pilot different methods of recording time prior to April 1, 2014 to determine which one will work best for them.

Does that mean I can only bill for the total time spent? What about services that are described as "major portion thereof", "portion thereof" or "cumulative time"?
This new rule is not meant to preclude any billings, so long as the physician has spent time providing a service that is:

- *more than half of the time that is described in the HSC for codes that are described as "major portion thereof" (see GR 2.3.5 for more information).*
- *any portion of time for codes that are described as "portion thereof" (see GR 2.3.4 for more information).*
- *cumulative time added up and divided by the amount of time in the HSC. Each call must be a full amount of time as described in the HSC in order to claim more than one call. The last call must be the major portion of the amount of time described in the HSC (see GR 2.3.2 for more information).*

What are some examples of time based modifiers?
CMGP, CMXV, CMXC, COINPT, etc.

What if I work in two or more locations on the same day (i.e., my clinic, LTC and the hospital)?
Since travel time is not a service that is billable to AH, be sure to subtract your travel time particularly if you choose to have a single start and end time entry for the day. Another option is to have multiple entries; one start and end time for each location.

How do I record start and end times when I am on-call?
If you work a call shift, you could:

- *make multiple entries in your log book for the time spent each time you returned to the facility to provide patient management activities.*
- *use an electronic method such as an app that will allow multiple entries on a single date.*

COMX COMX modifier is being **DELETED** and replaced with COINPT

COINPT **COMPLEX INPATIENT CARE - (Explicit) - This modifier is used to indicate management of a complex hospital inpatient, or a long term care (LTC) patient for palliative care or intercurrent illness when the conditions to claim HSCs 03.03D or 03.03AR are met.**

1. May only be claimed once per patient, per physician, per day.

2. May only be claimed for the management of complex hospital inpatients with multi-system disease:

- whose co-morbidities contribute to complicating or increasing the care required by the claiming physicians involved in the care of the patient; and

- whose care requires that the physician spend 20 minutes or more per day on management of the patient's ongoing care.

3. May not be claimed for transfer of care where the receiving physician requires time to familiarize him/herself with the patient unless the conditions outlined in (2) above are met.

AMA NOTES: *COINPT for LTC patients only applies to HSC 03.03D when LTC patients are suffering from acute inter-current illness, and the physician spends 20 minutes or more delivering care.*

03.01NM **Patient care advice to a pharmacist provided via telephone or other telecommunication methods in relation to the care and treatment of a patient $12.10**

NOTE: 1. It is expected that the purpose of the communication will be to seek the advice/opinion or to inform a physician when changes such as but not limited to prescription adaptations, pharmacist initiated prescriptions, care plans or medication reviews have occurred.

2. May only be claimed when the pharmacist has initiated the communication and the physician has provided an opinion or recommendation for patient treatment.

3. May not be claimed where the primary purpose of the communication is to clarify, decipher or interpret the physician's handwriting and/or written instructions.

4. May not be claimed for the authorization of repeat prescriptions for which long-term repeats would more properly have been authorized at the time of writing the initial prescription.

5. May not be claimed for instances where a physician directs a patient to request the pharmacist to contact the physician.

6. May not be claimed for patients in an active treatment, auxiliary, or nursing home facility.

7. May not be claimed when a physician proxy, e.g. nurse or clerk, provides advice to the pharmacist.

8. A maximum of one (1) communication per patient per day may be claimed, regardless of the number of issues or concerns discussed with the pharmacist.

9. Where more than one patient is discussed in a single communication, a claim may be submitted with respect to each patient discussed.

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

11. To be claimed using the Personal Health Number of the patient.

12. Documentation of the communication must be recorded in their respective records.

FAQ's:

What does this fee code actually pay for?

*This new code compensates the physician, **only** when the pharmacist has initiated the communication with the physician **and** when the physician has provided their opinion or agreement with the pharmacist for:*

- *Rx adaptations.*
- *when a pharmacist completes a pharmacist's care plan on behalf of the patient and sends a copy to the patient's physician.*

This code does not compensate the physician for the any of the following activities:

- *physician initiated communication with the pharmacist, or the physician has directed the patient to have the pharmacist contact the physician.*
- *clarification of illegible or difficult to read script.*
- *renewal of an existing Rx if a longer term Rx should have originally been written.*
- *in person communication with a pharmacist, e.g. PCN pharmacist, facility pharmacist.*
- *providing advice about a hospital, facility or LTC in-patient.*
- *nurse, proxy, clerk, etc. provided advice without the physician's participation/authorization.*
- *filing of pharmacist communication, where no communication back to pharmacist has occurred.*

03.01O Physician to Physician E-Consultation, consultant.....$74.18

NOTES: 1. May only be claimed when both the request and response are sent by electronic means. 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:

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.

FAQ's:

This code is for the consulting physician, what does the referring physician bill?
The referring physician would include the time spent writing of the referral letter in a claim for the patient using complexity modifiers (CMGP, CMXV, CMXC, COINPT, etc.), provided that a visit service occurred on the date of service that the referral letter was written.

What if the consultant can't or doesn't reply with advice or management information within thirty (30) days?

- *If the consultant doesn't reply within thirty days (unless special accommodations were made and communicated to the referring physician in writing prior to the expiration of the thirty days), the consultant may not submit a claim for the service.*
- *Where the consultant cannot provide advice or patient management options, a claim cannot be submitted. The referring physician must be advised of the inability to fulfill the request.*

- *A response or lack of response from the consultant does not preclude the referring physician from claiming for their time spent preparing the referral letter/information using the complexity modifiers.*

How can I find out more about the email security guidelines?
Please refer to the CPSA for information re email security guidelines. This information can be found using the following links:

EMR Forum regarding "Emailing Patient Information":
www.cpsa.ab.ca/Resources/the-messenger/EMRForum/emr-forum/2012/03/30/Emailing_Patient_Information.aspx

Standard 21: Patient Records (electronic and paper):
www.cpsa.ab.ca/Resources/StandardsPractice/PracticeManagement/patient-records

Other resources from the Office of the Information and Privacy Commissioner of Alberta:
- www.cpsa.ab.ca/Libraries/Res_Advice_to_the_Profession/Email_Know_the_Risks.pdf
- www.cpsa.ab.ca/Libraries/Res_Advice_to_the_Profession/Email_FAQs.pdf

03.04Q **Post surgical cancer surveillance examination.....$98.78**

NOTE: 1. Intended for patients requiring scheduled comprehensive evaluations adhering to protocols as defined by the facility, program or surgeon from which the patient was discharged.

2. The discharge letter that states the protocols must be forwarded to Alberta Health for claim processing for each claim submitted.

AMA NOTES: *The discharge letter must be faxed to AH (780.422.3552) each time a claim is made for 03.04Q. Please write the claim number at the top of the discharge letter to facilitate claims processing.*

CHANGES APPLICABLE TO ALL PHYSICIANS

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

GR 1.10 "Telehealth" service is defined as a physician delivered health service through the use of videotechnology, including store and forward, that is provided to a patient who is in attendance at a regional health authority telehealth site or a registered Health Canada health centre or nursing station site at the time of the video capture. Telehealth services do not include teleradiology. **The physician must provide the service at a regional health authority telehealth site or a registered Health Canada health centre or nursing station site in order to submit a claim.**

GR 1.27 When claiming for telecommunication and telephone call services, the location of the physician at the time of the service should be used on the claim.

GR 1.28 "Regional facility" means any facility owned and operated by Alberta Health Services.

GR 1.29 "Weekend(s)" means Saturday and Sunday.

GR 2.3.1 Unless otherwise specified, services that may be claimed once per year may be claimed 365 days after the previous service date **or 366 days in a leap year**.

GR 2.3.6 When billing time based services, including modifiers, the physician must document the time spent providing time based services for each day of service (as defined in GR 1.19). The record must be available upon request and should be kept in chronological order, for each day. The total time claimed for time based services in a single day cannot exceed the total time spent delivering patient care activities in relation to an insured service. Claims for services that are described as cumulative time, major portion thereof or portion thereof may continue to be submitted in accordance to GR's 2.3.2, 2.3.4 and 2.3.5.

AMA NOTES: *Please see HIGHLIGHTS portion of the Billing Corner for additional information.*

GR 4.4.8 Claims requiring referring practitioner number:

<u>Add HSCs</u>:

03.44A Infusion for purposes of pharmacologic stress imaging
09.07C Bilateral dark adaptation study – technical and interpretation
09.12B Intravenous fluorescein angiography (IVFA), technical
28.81A Biopsy of retina or choroid including intraoperative laser

<u>Delete HSCs</u>:

03.19A, 03.19B, 09.07A, 09.07B, 09.13B, 09.16A, 09.21A, 09.21B, 09.22A, 09.22B, 09.24A, 09.26B, 09.26C, 24.81, 28.81, 29.81, 49.98A

GR 4.6.1 Comprehensive visits and/or comprehensive/major consultations may only be claimed once every 180 days per patient by the same physician. Comprehensive visit and consultation services are defined as HSCs 03.04A, 03.08 series, 03.09B, 08.11A, 08.11C, 08.19A and 08.19AA. There must be an interval of 180 days between the first and second comprehensive services. **HSCs 03.04O and 03.04P are defined as comprehensive services and may not be billed more frequently than four times per year as indicated or within 180 days of a comprehensive service or consultation by the same physician.**

GR 6.5 Non-invasive diagnostic procedures in hospital, AACC or UCC:

Add HSCs:

03.44A Infusion for purposes of pharmacologic stress imaging
09.07C Bilateral dark adaptation study – technical and interpretation
09.12B Intravenous fluorescein angiography (IVFA), technical
49.98T Interpretation of transtelephonic ECG or rhythm strip

Delete HSCs:

03.19A, 03.19B, 09.07A, 09.07B, 09.13B, 09.21A, 09.21B, 09.22A, 09.22B, 09.24A, 09.26B, 09.26C

GR 7.1.1 FUNCTIONAL AREA Functional area includes the following anatomical areas: Head, face, neck, shoulder, axilla, elbow, wrist, hand, groin, perineum, **hip,** knee, ankle, foot, and includes coverage of exposed vital structures (bone, tendon, major vessel, nerve).

GR 9.1.2

Add HSCs:

09.02E Amblyopia evaluation for patients nine years of age or younger
09.12B Intravenous fluorescein angiography (IVFA), technical
25.81A Diagnostic corneal scraping

Delete HSCs:

09.26B, 09.26C, 21.32A

GR 9.1.3

Add HSCs:

09.02E Amblyopia evaluation for patients nine years of age or younger
09.12B Intravenous fluorescein angiography (IVFA), technical
25.81A Diagnostic corneal scraping

Delete HSCs:

09.26B, 09.26C

GR 11.2.3 EVOKED POTENTIAL A claim for HSCs ~~**03.19B**~~, 03.19C, 09.21B, 09.23B and 09.46A may be submitted by physicians who have been approved by the CPSA to provide these services.

HEALTH SERVICE CODES (Note: Wording in **bold** indicates changes)

03.01NM **Patient care advice to a pharmacist provided via telephone or other telecommunication methods in relation to the care and treatment of a patient $12.10**

NOTE: 1. It is expected that the purpose of the communication will be to seek the advice/opinion or to inform a physician when changes such as but not limited to prescription adaptations, pharmacist initiated prescriptions, care plans or medication reviews have occurred.

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5. May not be claimed for instances where a physician directs a patient to request the pharmacist to contact the physician.

6. May not be claimed for patients in an active treatment, auxiliary, or nursing home facility.

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9. Where more than one patient is discussed in a single communication, a claim may be submitted with respect to each patient discussed.

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

11. To be claimed using the Personal Health Number of the patient.

12. Documentation of the communication must be recorded in their respective records.

AMA NOTES: *Please see HIGHLIGHTS portion of the Billing Corner for additional information.*

03.01O **Physician to Physician E-Consultation, consultant.....$74.18**

NOTES: 1. May only be claimed when both the request and response are sent by electronic means. 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:

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.

AMA NOTES: *Please see HIGHLIGHTS portion of the Billing Corner for additional information.*

03.04Q **Post surgical cancer surveillance examination.....$98.78**

NOTE: 1. Intended for patients requiring scheduled comprehensive evaluations adhering to protocols as defined by the facility, program or surgeon from which the patient was discharged.

2. The discharge letter that states the protocols must be forwarded to Alberta Health for claim processing for each claim submitted.

AMA NOTES: *The discharge letter must be faxed to AH (780.422.3552) each time a claim is made for 03.04Q. Please write the claim number at the top of the discharge letter to facilitate claims processing.*

03.05G Care of healthy newborn in hospital **(first day)**

03.05GA **Care of healthy newborn in hospital (subsequent days).....~~$40.58~~**

NOTE: May only be claimed when no other visit service has been provided on that day, regardless of physician.

13.42A Desensitization treatments with ~~autogenous vaccines~~ **allergy serums**

NOTE: 1. When performed by physician or under physician supervision.

2. A maximum of one office visit per month may be claimed for reassessment of the patient in lieu of a claim for desensitizing injection.

3. Benefit includes cost of all material other than allergy serum.

4. Only one benefit may be claimed per treatment regardless of number of injections given.

13.59A Intramuscular or subcutaneous injections

NOTE: **1.** May be claimed in addition to a visit or a consultation.

2. May not be claimed for injection of allergy serum.

13.59O Injections of Botulinum A Toxin for the prophylaxis of chronic migraine headaches for eligible patients 18-65 years of age.....$99.90

NOTE: 1. Eligible patients will have suffered headache activity for greater than 15 days per month with each episode lasting for four or more hours for three consecutive months prior to the initial treatment.

2. Follow up treatment may be claimed in 12 week intervals.

3. Only one call may be claimed regardless of the number of injections performed.

4. May be claimed in addition to a visit or a consultation.

Added to GRs 6.8.4 and 14.2

40.1 Tonsillectomy for patient 14 years of age and over

The Surgical Assist modifier SA has been added.

46.04B
50.51A
50.81A
50.87A
50.94E
50.99B
63.99B
67.02
92.70
92.71
92.72
92.74
92.75
92.76
92.78C
95.96A

These codes have been amended to include the L40 modifier.

50.99B has been amended to include L13 modifier as well as L40.

67.02 has been amended to include the CAGE (corrected age) modifier as well as L40.

66.4 A Lysis of adhesions.....$74.99

NOTE: 1. May only be claimed when a full 15 minutes has been spent on adhesions. Each subsequent 15 minutes or major portion thereof may be claimed at the rate specified on the Price List.

2. May not be claimed in addition to procedures billed with REDO modifier(s).

3. May not be claimed in addition to HSCs 58.42A, 58.44A, 58.81A, 58.81B, 58.81C and 81.29C.

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

New modifier added to SOMB. This replaces the COMX modifier:

COINPT COMPLEX INPATIENT CARE - (Explicit) - This modifier is used to indicate management of a complex hospital inpatient, or a long term care (LTC) patient for palliative care or intercurrent illness when the conditions to claim HSCs 03.03D or 03.03AR are met.

1. May only be claimed once per patient, per physician, per day.

2. May only be claimed for the management of complex hospital inpatients with multi-system disease:

- whose co-morbidities contribute to complicating or increasing the care required by the claiming physicians involved in the care of the patient; and

- whose care requires that the physician spend 20 minutes or more per day on management of the patient's ongoing care.

3. May not be claimed for transfer of care where the receiving physician requires time to familiarize him/herself with the patient unless the conditions outlined in (2) above are met.

03.03AR Amend Price List as indicated:

44.90	CARE ~~COMX~~ **COINPT**	Y	Increase Base By	39.29

AMA NOTES: *COINPT for LTC patients only applies to HSC 03.03D when LTC patients are suffering from acute inter-current illness, and the physician spends 20 minutes or more delivering care.*

03.03D Hospital visits:

NOTE: 1. Specialist rates are for referred hospital visits only.

2. A maximum of six level one days may be claimed when the same physician claims a comprehensive visit or consultation on the date of hospital admission.

3. Only one HSC 03.03D may be claimed per patient, per physician, per day. Special callbacks (HSCs 03.05N, 03.05P, 03.05QA, 03.05QB, 03.05R) may be claimed when the criteria listed under HSC 03.05R are met.

4. Modifier ~~COMX~~ **COINPT** may be claimed for the management of complex acute care hospital inpatients with multi-system disease. Refer to the ~~COMX~~ **COINPT** modifier definition for clarification regarding the use of this modifier.

40.58	CARE ~~COMX~~ **COINPT**	Y	Increase Base By	39.29

COMX **DELETED** from SOMB: COMX COMPLEX PATIENT CARE - (Explicit)
Please use new modifier COINPT. This change allows the modifier to be billed in LTC settings.

SECTION OF ANESTHESIA

Health Service Codes

02.82A is no longer applicable for TEE by ANES, please use 49.99AA

11.02
12.12B
12.13A
54.21C
54.21D
54.21E
54.92E
55.41A
55.41B
56.34A
58.39B
82.64A
86.49A

These codes have been amended to include ANE.

BMI	**BMIANE**	**Y**	**Increase By**	**25% M**
ROLE	**ANE**	**Y**	**Replace Base**	**107.37**
VANE	**ADDA**		**Replace**	**107.37**

49.99AA **Intraoperative trans-esophageal echocardiography, procedure and interpretation $135.92**

NOTE: May not be claimed by the surgeon if performed intraoperatively.

51.65B Sedation for cannulation/decannulation

NOTE: May not be claimed by the same physician who is claiming anaesthetic services for HSCs 51.65A, 51.65C or 51.65D.

19.09A
39.0 A - (dental code)
39.0 B - (dental code)
47.23A
47.25A
47.27A
47.29A
48.12
48.12A
48.13
48.13A
48.14
48.14A
48.15A
48.15B
48.15E
49.5 A
50.99B **These codes have been amended to include 2ANE/2ANES.**
51.29E
51.65A
51.65C
51.65D
57.6 A
57.6 B
57.6 C
57.6 D
57.6 E
62.4
66.19D
67.4 C
67.4 D
74.4 E
96.15
96.16
96.17

BMI	**BMI2AN**	**Y Increase By**	**25%**
ROLE	**2ANES**	**Y Replace Base**	**21.70**
2ANU	**2ANU**		
	1	**For Each Call Pay Base At**	**100%**
		For Each Call Increase By	**21.70**

SECTION OF CARDIOLOGY

Health Service Codes

02.82A is no longer applicable for intra-operative TEE, please use 49.99AA

02.82A **Comprehensive diagnostic** ~~T~~trans-esophageal echocardiography, ~~procedure and interpretation~~

NOTE: **1.** ~~May not be claimed by the surgeon if performed intraoperatively~~ **Benefit includes 2D, M-mode, Doppler, 3D acquisition and post-processing and bubble study if indicated**.

2. May be claimed in addition to HSC 13.72A.

3. May be claimed in addition to a visit or a consultation.

4. May not be claimed for services provided intraoperatively.

02.83A Intravascular ultrasound (IVUS), additional benefit $115.00

NOTE: May only be claimed in addition to HSCs 48.98A, 48.98B, 48.92A, 49.96A, 49.98B, 51.59D, 51.59E and 51.59F.

03.41A Maximal stress electrocardiogram, **with or without pulse oximetry,** technical only

NOTE: 1. Utilizing bicycle ergometer or treadmill.

2. Includes resting electrocardiograms before and after the procedure.

03.41C Continuous, **with or without pulse oximetry,** personal physician monitoring

NOTE: 1. Utilizing bicycle ergometer or treadmill.

2. Benefit includes resting electrocardiograms before and after the procedure.

03.44A Infusion for purposes of pharmacologic stress imaging $181.51

NOTE: Benefit includes resting electrocardiograms before and after the procedure.

Added to GRs 11.2 and 13.3

47.25E Transcatheter aortic valve replacement (TAVR).....$1600.00

47.29B Transcatheter pulmonary valve replacement $2094.35

48.98B Coronary angiography

NOTE: May not be claimed in addition to HSC 50.91A.

49.7 JA
49.7 KA
49.7 LA
49.7 MA

Amend Note 2 to read:

2. May not be claimed in addition to electrophysiology studies (HSCs 49.98~~F~~**AA** through 49.98Y).

49.82B Amend Price List as indicated:

LVP	**LVP50**	**Y**	**Reduce Base To**	**50%**

49.95A Right cardiac catheterization with fluoroscopy
NOTE: May not be claimed in addition to HSC 50.94D.

49.96B Trans-septal heart cathe**te**rization with fluoroscopy
NOTE: May not be claimed in addition to HSCs 49.98AA, 49.98AB and 49.98AC.

49.98A Delete

49.98AA Diagnostic Electrophysiological (EP) study with or without Drug challenge AV node ablation or defibrillation testing.....$663.21
NOTE: 1. May not be claimed in addition to HSC 49.96B.
2. Refer to the notes following 49.98Y.

49.98AB Complex ablation of arrhythmic substrate(s) $2216.52
NOTE: 1. May not be claimed in addition to HSC 49.96B.
2. Refer to the notes following 49.98Y.

49.98AC Standard ablation of arrhythmic substrate $1221.70
NOTE: 1. May not be claimed in addition to HSC 49.96B.
2. Refer to the notes following 49.98Y.

49.98F
49.98G
49.98H
49.98J
49.98K Delete
49.98L
49.98M
49.98N
49.98V

49.98W Second operator at complicated EP studies per ~~30 mins.~~ **15 minutes or major portion thereof**

49.98W	47.45	CALL M~~30~~**15**			
			1	For Each Call Pay Base At	100%
			2-~~5~~**10**	For Each Call Increase By	**23.80**

49.98Y Cardioversion

NOTE: ~~1. Any combination of HSCs 49.98F through 49.98Y may be claimed to a maximum of $1,290.12 for diagnostic procedures.~~

1. These are not to be claimed in association with HSCs outside of the electrophysiology studies (EPS) section.

2. These may only be claimed when performed in a hospital.

~~4. HSC 49.98V may be claimed in association with diagnostic procedures to a maximum of $1,344.97.~~

3. HSC 49.98Y may only be claimed when performed with EPS HSCs **(49.98AA through 49.98U)**. When it is not performed with EPS, then HSC 13.72A should be claimed.

49.99A Transesophageal echocardiography guidance for percutaneous procedures, per 30 minutes or major portion thereof $136.13

NOTE: 1. May not be claimed in addition to HSC 02.82A.

2. May not be claimed by the surgeon.

49.99AA Intraoperative trans-esophageal echocardiography, procedure and interpretation $135.92

NOTE: May not be claimed by the surgeon if performed intraoperatively.

50.91A Introduction of arterial catheter for pressure monitoring and/or blood gas monitoring percutaneous or by cutdown

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.

51.59G Device assisted percutaneous coronary intervention including but not exclusive to rotoblation, retrograde total occlusions and clot aspiration devices, additional benefit $180.00

Note: May only be claimed in addition to 51.59D, 51.59E and 51.59F.

SECTION OF CARDIOVASCULAR AND THORACIC SURGEONS

Health Service Codes

47.02C **Mitral valve repair through mini thoracotomy $2220.64**
Add to GR 13.3 and 6.15.4

47.23B **Mitral valve replacement through mini thoracotomy $2220.64**

47.03A Amend Price List as indicated:

971.89	**ROLE SSCVT**	**Y Replace Base**	**305.35**

47.25E **Transcatheter aortic valve replacement (TAVR)**
AMA NOTES: CTSG surgeons participating in TAVR cases would bill 47.25E with a SSCVT modifier.

SECTION OF DERMATOLOGY AND DERMATOLOGIC SURGERY

Health Service Codes

13.59O **Injections of Botulinum A Toxin for the prophylaxis of chronic migraine headaches for eligible patients 18-65 years of age.....$99.90**

NOTE: 1. Eligible patients will have suffered headache activity for greater than 15 days per month with each episode lasting for four or more hours for three consecutive months prior to the initial treatment.

2. Follow up treatment may be claimed in 12 week intervals.

3. Only one call may be claimed regardless of the number of injections performed.

4. May be claimed in addition to a visit or a consultation.

Added to GRs 6.8.4 and 14.2

98.12VA **Laser resurfacing of scars including burn scars, non-functional area, up to 32 total square cms.....$135.73**

NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.

98.12VB **Laser resurfacing of scars including burn scars, non-functional area, over 32 and up to 64 total square cms.....$226.87**

NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.

98.12VC **Laser resurfacing of scars including burn scars, non-functional area, over 64 and up to 100 total square cms.....$352.30**

NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.

98.12VD **Laser resurfacing of scars including burn scars, non-functional area, over 100 total square cms.....$504.20**

NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.

98.12VE **Laser resurfacing of scars including burn scars, functional area, up to 32 total square cms $176.40**

NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.

98.12VF **Laser resurfacing of scars including burn scars, functional area, over 32 and up to 64 total square cms.....$302.32**

NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.

98.12VG Laser resurfacing of scars including burn scars, functional area, over 64 total square cms $504.20
NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.

98.13A Melanoma, excision ~~with skin graft~~, excluding face

SECTION OF DIAGNOSTIC IMAGING

Health Service Codes

16.89D Percutaneous facet joint injection - Lumbar/Sacral
NOTE: 1. A maximum of four calls may be made per patient, per day regardless of level (HSCs 16.89B, 16.89C or 16.89D).
2. A maximum of twelve calls may be claimed per patient, per **benefit** year regardless of level (HSCs 16.89B, 16.89C or 16.89D).

50.34L **Add DIRD to list of eligible skills**

92.8 D Arthroscopy, (wrist, elbow, ankle, shoulder**, knee**) therapeutic intervention, including debridement/drilling, etc.
NOTE: May not be billed in addition to HSCs 92.32B, 92.32C or 92.32D.

X 3
X 3A
X 11
X 14
X 24
X 72
X 74
X 75
X 76
X 77
X 78
X 83
X 85A
X 89
X 90
X 91
X 92
X 93
X107F
X152
X154
X155
X254

Delete

X 82A Double contrast examination of stomach - additional fee to X 82, ~~**X 83**~~ and X 84

X128 Bone mineral content determination dual photon absorptiometry **with or without vertebral fracture assessment (VFA)**

X301 Amend heading as indicated each time it appears in the SOMB:

DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.

2. Ultrasound benefits include Doppler colour mapping.

3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306, X323, X331, X332 and X333.

4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day.

X331 Ultrasound, arterial screening, peripheral. Add heading:

Peripheral Vascular System

NOTE: These HSCs can be claimed on any combination of limbs as determined by clinical evaluation.

X337 Doppler, quantitative spectral analysis with directional flow and/or Doppler measurements (e.g. renal artery, portal venous system, resistivity index, etc.), additional benefit

NOTE: May not be billed in addition to HSCs X304, X306, X323, X330, X331, X332 and X333 **when services are provided by the same or different physician in the same facility on the same day**.

SECTION OF EMERGENCY MEDICINE

Health Service Codes

08.19N Renewal, amendments, cancellation or expiry of a CTO as well as necessary work involved in the completion of an apprehension order, examination on apprehension, written statement or non-compliance report, per full 15 minutes

NOTE: 1. To be claimed by the psychiatrist most responsible**,** or physician designated by Alberta Health Services to perform this service **or in the case of examination on apprehension by an emergency room physician**.

2. May not be claimed for travel time or direct psychiatric

treatment with the patient. Claims for direct psychiatric treatment should be submitted using the appropriate HSC.

3. Benefit includes form completion and communication to community physician(s), and other health practitioners involved in the care of the patient.

08.19N	44.90	**SKLL EMSP**	**Replace Base**	44.90 V
		SKLL FTER	**Replace Base**	**44.90**

SECTION OF GASTROENTEROLOGY

Health Service Codes

01.24A Rigid proctosigmoidoscopy
NOTE: 1. HSC 58.99D may be claimed in addition.
~~2. May not be claimed in addition to HSC 61.12A.~~
~~3~~ **2**. Benefit includes biopsies and/or polypectomies.

01.24B Flexible proctosigmoidoscopy, diagnostic only
NOTE: 1. **May only be claimed in addition to** HSC**s 13.99AE, 57.13A, 57.21A, 57.21B, 58.99C and** 58.99D ~~may be claimed in addition~~.
~~2. May not be claimed in addition to HSC 61.12A.~~
~~3~~ **2**. Benefit includes biopsies ~~and/or polypectomies~~.
Note 2 is being deleted as it is redundant with GR 6.9.8

01.24BA Flexible proctosigmoidoscopy for screening of patients considered to be of high risk for colon cancer due to a family history of Familial Adenomatous Polyposis (FAP)
NOTE: 1. **May only be claimed in addition to** HSC**s 57.13A, 57.21A, 57.21B, and** 58.99D ~~may be claimed in addition~~.
2. Benefit includes biopsies ~~and/or polypectomies~~.
3. May be claimed once every year beginning at the age of 10.

01.24BB Flexible proctosigmoidoscopy for screening of patients who are considered to be of average risk for colon cancer
NOTE: 1. **May only be claimed in addition to** HSCs **57.13A, 57.21A, 57.21B, and** 58.99D ~~may be claimed in addition~~.
2. Benefit includes biopsies ~~and/or polypectomies~~.
3. Average risk is defined as an individual who is asymptomatic and aged 50 to 74 years.
4. May be claimed once every 5 years.

13.99AE Placement of colonic stent ~~via colonoscope~~, additional benefit
NOTE: May only be claimed in addition to HSC**s** 01.22 **and 01.24B**.

57.13A Bipolar electrocoagulation/heater probe haemostasis ~~for small vascular abnormalities of caecum~~ **or endoclip placement or argon plasma coagulation for bleeding lesions of the colon**
NOTE: 1. May only be claimed in addition to HSCs 01.16B, ~~01.16C~~, 01.22, 01.22A, 01.22B**,** ~~and~~ 01.22C**, 01.24B, 01.24BA and 01.24BB**.
2. May ~~not~~ be claimed for ~~control of bleeding, following Polypectomies~~ **post-polypectomy bleeding where a repeat procedure is required following the initial procedure**.

57.21B Injection haemostasis
For vascular abnormalities of colon
NOTE: 1. May not be claimed for control of bleeding, following polypectomies.
2. Maximum of one per sitting irrespective of the number of sites involved.
3. May only be claimed in addition to HSCs 01.22, 01.22A, 01.22B**,** ~~and~~ 01.22C**, 01.24B, 01.24BA and 01.24BB**.
4. May be claimed in addition to HSC 57.21C if polyps are removed from a different site.

57.21C Removal of sessile polyp ~~via colonoscope~~, additional benefit
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. A maximum of two calls applies.

58.99C Balloon dilatation of lower gastrointestinal (ileum or colonic) stricture
NOTE: 1. May only be claimed in addition to HSCs 01.16B, 01.16C, 01.22, 01.22A, 01.22B**,** ~~and~~ 01.22C **and 01.24B**.
2. A repeat performed within 90 days is payable at 50%.

63.86A ~~Transection of papilla~~ **Billary sphincteroplasty, dilation of the ampulla** of Vater ~~by electrocautery~~
NOTE: May only be claimed in addition to 64.97A.

SECTION OF GENERAL INTERNAL MEDICINE

Health Service Codes

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** and vascular surgery (no age restriction).

03.03FA	25.43	**SKLL HEM**	**Replace Base**	**48.06**

03.08I Prolonged endocrinology/ metabolism, gastroenterology, **hematology,** infectious diseases, internal medicine, **nephrology,** physiatry or neurology consultation or visit, full 15 minutes or major portion thereof for the first call when only one call is claimed

NOTE: May only be claimed in addition to HSCs 03.04A, 03.04C, 03.07B and 03.08A when these services exceed 30 minutes.

03.08I	$**18.00**	**SKLL HEM**	**Replace Base**	**$46.44**
		CALL M15		
		1- **6**	For Each Call Pay Base At	100%

13.99O Management of dialysis patients on home dialysis or receiving treatment in a remote hemodialysis unit (per week)

Note 1: **May only be claimed by internal medicine specialists.**

2. May be claimed for patients on either hemodialysis or peritoneal dialysis.

3. May not be claimed in addition to HSC 13.99B and 13.99D within the same calendar week unless documentation to support the claim is provided.

4. May be claimed once per patient within the same calendar week if not preceded by any visit except those outlined in Note 4.

5. HSC 03.03AR, 03.03DF and special callback benefits (HSCs 03.05N, 03.05P, 03.05QA, 03.05QB, 03.05R) may be claimed within the same calendar week for the same patient by the same physician.

6. The physician must be actively involved in the management of the patient's care in order to claim.

SECTION OF GENERAL PRACTICE

Modifier

CMGP COMPLEX PATIENT VISIT - (Explicit) - This modifier is used to indicate a complex patient visit requiring that the physician spend 15 minutes or more on management of the patient's care. EACH ADDITIONAL UNIT REPRESENTS 10 MINUTES. ADDITIONAL UNITS MAY NOT BE CLAIMED UNLESS A FULL 10 MINUTES HAS ELAPSED. (Example: CMGP03 indicates a general practice physician has spent a minimum of 35 minutes with the patient. The first unit represents 15 minutes and each subsequent unit represents 10 minutes.) **A maximum of 10 calls may be claimed**. May only be claimed by general practitioners for HSCs 03.01J, 03.03A, 03.03B, 03.03C, 03.03N, 03.03P, 03.03Q, 03.07A, 03.07B.

Health Service Codes

03.04J **Amend text in Note 5:**

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

Group A	Group B
-Hypertensive Disease	-Mental Health Issues
-Diabetes Mellitus	-Obesity (Adult = BMI 35 or
-Chronic Obstructive Pulmonary	greater Child = 97 percentile)
Disease	-Addictions
-Asthma	-Tobacco
-Heart Failure	
-Ischaemic Heart Disease	
-Chronic Renal Failure (ICD-9 585 to 586)	

03.04Q Post surgical cancer surveillance examination.....$98.78

NOTE: 1. Intended for patients requiring scheduled comprehensive evaluations adhering to protocols as defined by the facility, program or surgeon from which the patient was discharged.

2. The discharge letter that states the protocols must be forwarded to Alberta Health for claim processing for each claim submitted.

AMA NOTES: *The discharge letter must be faxed to AH (780.422.3552) each time a claim is made for 03.04Q. Please write the claim number at the top of the discharge letter to facilitate claims processing.*

03.05G Care of healthy newborn in hospital **(first day)**

03.05GA Care of healthy newborn in hospital (subsequent days).....$40.58
NOTE: May only be claimed when no other visit service has been provided on that day, regardless of physician.

10.16B Pessary removal, adjustment and/or reinsertion $13.00
NOTE: May not be claimed in addition to HSC 10.16A
Please note, this service is billable in addition to a visit or a consultation. A note will be added to state this in the near future.

11.71A Removal of intrauterine contraceptive device (IUD).....$13.00
Please note, this service is billable in addition to a visit or a consultation. A note will be added to state this in the near future.

84.21B
84.21C
Delete HSCs from SOMB
Please use new code 84.21D

84.21D Assisted delivery, forceps, vacuum with or without rotation, mid or lower cavity $130.00
NOTE: May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.

87.99A **Non-surgical ~~M~~ m**anagement of post partum hemorrhage
NOTE: 1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.
2. May be claimed in addition to a consultation.

87.99AA Surgical management of severe post partum hemorrhage including but not limited to the use of an intrauterine balloon device or suturing encircling the uterus $149.10
Added to GR 13.3

91.08C
91.13B
Delete

98.13A Melanoma, excision ~~with skin graft~~, excluding face

SECTION OF GENERAL PSYCHIATRY

Health Service Codes

03.01B
03.01BA
03.01BB

These codes have been amended to include:

"~~Home~~**Patient** care advice provided to community mental health care workers, **child protection workers, group home staff, or educational personnel…"**

03.05Y Formal, scheduled, professional interview, case conference with other physicians and/or direct therapeutic supervision of allied health professionals, educational or other community agencies on behalf of a specific patient, provided by the physician most responsible for the patient's care

NOTE: 1. May not be claimed unless the physician has seen the patient and been directly involved in the patient's care.

2. May only be claimed by:

- pediatricians (including subspecialties) for patients 18 years of age and under
- medical geneticists **and psychiatrists** (no age restriction) when a minimum of 30 minutes has been spent.

3. A maximum benefit of 3 hours applies per session.

4. A maximum benefit of 6 hours per patient, per physician, per benefit year, applies.

5. This service is to be claimed using the Personal Health Number of the patient.

6. HSC 03.03D may be claimed on the same day.

08.44A
08.44B
08.44C
08.44D

These codes have been amended to include the following note:

"**Group therapy services for patients 18 years of age or younger may be claimed using HSC 08.44C or 08.44D."**

SECTION OF GENERAL SURGERY

Health Service Codes

01.24A Rigid proctosigmoidoscopy

NOTE: 1. HSC 58.99D may be claimed in addition.

~~2. May not be claimed in addition to HSC 61.12A.~~

~~3~~ **2**. Benefit includes biopsies and/or polypectomies.

01.24B Flexible proctosigmoidoscopy, diagnostic only

NOTE: 1. **May only be claimed in addition to** HSC**s 13.99AE, 57.13A, 57.21A, 57.21B, 58.99C and** 58.99D ~~may be claimed in addition~~.

~~2. May not be claimed in addition to HSC 61.12A.~~

~~3~~ **2**. Benefit includes biopsies ~~and/or polypectomies~~.

Note 2 is being deleted as it is redundant with GR 6.9.8

01.24BA Flexible proctosigmoidoscopy for screening of patients considered to be of high risk for colon cancer due to a family history of Familial Adenomatous Polyposis (FAP)

NOTE: 1. **May only be claimed in addition to** HSC**s 57.13A, 57.21A, 57.21B, and** 58.99D ~~may be claimed in addition~~.

2. Benefit includes biopsies ~~and/or polypectomies~~.

3. May be claimed once every year beginning at the age of 10.

01.24BB Flexible proctosigmoidoscopy for screening of patients who are considered to be of average risk for colon cancer

NOTE: 1. **May only be claimed in addition to** HSCs **57.13A, 57.21A, 57.21B, and** 58.99D ~~may be claimed in addition~~.

2. Benefit includes biopsies ~~and/or polypectomies~~.

3. Average risk is defined as an individual who is asymptomatic and aged 50 to 74 years.

4. May be claimed once every 5 years.

03.03AO Transfer of care of hospital in-patient

NOTE: 1. May only be claimed by endocrinology/metabolism, general internal medicine, **general surgery,** cardiology, hematology, clinical immunology, medical oncology, and respiratory medicine.

2. May be claimed on the date of transfer by the receiving physician when assuming responsibility for care of a hospital in-patient.

3. Only one transfer may be claimed per patient, per calendar week, regardless of whether the same or different physician provides the service.

4. The physician from whom the care is being transferred may claim a hospital visit or intensive care visit on the day of transfer.

5. May not be claimed for weekend coverage or within 24 hours of admission to hospital.

6. May not be claimed during post-operative time periods unless complications occur.

03.03AO **89.98** **SKLL GNSG** **Replace Base** **89.98**

AMA NOTES: *Note 6 refers specifically for general surgeons, this means that 03.03AO may not be claimed for instances where a patient is transferred from one general surgeon to another general surgeon for routine post-operative care. This code may only be claimed by general surgery for cases where a patient is being medically managed outside of any inclusive care periods for a surgical procedure or as a result of post-operative complications.*

03.03AU Transfer of care of hospital in-patient or out-patient to operating physician

Note: 1. May only be claimed by **general surgery,** orthopedics **and urology**.

2. May only be claimed when a consultation for the patient has already been claimed by another physician of the same specialty.

3. May be claimed in addition to a procedure on the same date of service.

03.03AU **89.98** **SKLL GNSG** **Replace Base** **89.98**

13.99AE Placement of colonic stent ~~via colonoscope~~, additional benefit

NOTE: May only be claimed in addition to HSC**s** 01.22 **and 01.24B**.

55.9 AA **Total gastrectomy for malignancy $2114.58**

NOTE: May not be claimed with HSCs 52.43A, 55.9 A and 57.7.

57.6 F **Colon j pouch or coloplasty construction, additional benefit.....$149.97**

Note: May only be claimed in addition to HSC 60.52B.

57.7 Small to small intestinal anastomosis

Note: **1.** May be claimed for ileostomy closure **and/or stricturoplasty.**

2. May not be claimed in addition to HSC 57.42A.

57.21B Injection haemostasis

For vascular abnormalities of colon

NOTE: 1. May not be claimed for control of bleeding, following polypectomies.

2. Maximum of one per sitting irrespective of the number of sites involved.

3. May only be claimed in addition to HSCs 01.22, 01.22A, 01.22B**,** ~~and~~ 01.22C**, 01.24B, 01.24BA and 01.24BB**.

4. May be claimed in addition to HSC 57.21C if polyps are removed from a different site.

57.21C Removal of sessile polyp ~~via colonoscope~~, additional benefit

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. A maximum of two calls applies.

60.4 B Perineal portion of abdomin~~oal~~-perineal resection

NOTE: **1.** ~~This benefit~~ **May be claimed by the same or different physician regardless of who performed the abdominal portion of the surgery** ~~is for the second surgeon~~.

2. May only be claimed in addition to HSCs 57.6 B, 60.4 A and 60.52B.

60.52B Total mesorectal excision

NOTE: 1. May only be claimed for rectal **neoplasms (benign and or malignant tumors), or inflammatory bowel disease** ~~cancer~~.

2. May not be claimed in addition to HSCs 57.6 A, 57.6 B, 57.6 C, 57.6 D, 57.6 E and 58.81C.

3. HSCs 57.42A and 57.59A may only be claimed in addition when two discontinuous areas are resected and two anastomoses are performed. ~~Text indicating the areas that were resected is required.~~

4. May be claimed in addition to HSC 57.6 F.

AMA NOTES: *Unfortunately, the requirement for text was not removed from HSCs 57.42A and 57.59A. Therefore, the requirement for text on 60.52B will still be required until October 1, 2014 when the text requirement will be removed from 57.42A and 57.59A. Thank you for your patience.*

60.59B **Full thickness transanal or t**rans-sphincteric resection of rectum

60.65 Abdominal proctopexy

Note: May be claimed in addition to HSC 60.52A.

61.12A Delete HSC from SOMB

Anal Fistulectomy – please use new code 61.63A

61.63A Anal fistulotomy and other procedures for anal fistula $280.47

NOTE: 1. Benefit includes insertion of seton, fibrin glue injection, anal fistula plug insertion, ligation of intersphincteric fistula tract.

2. Maximum of three calls may be claimed per encounter.

3. Second and third calls may not be claimed unless treatment is performed on documented separate internal openings for each call at the same encounter.

64.81B Donor pancreas removal
Note: To be claimed under the ~~recipient~~ **donor** PHN.

65.9 D **Parastomal hernia repair (includes revision and/or relocation of ileostotomy/colostomy and the incisional hernia repair).....$1286.74**
NOTE: 1. May only be claimed in instances where the stoma has been re-sited.
2. May not be claimed in addition to other hernia repair procedures or bowel resection procedures.
3. Includes laparotomy and lysis of adhesions.

66.4 A **Lysis of adhesions.....$74.99**
NOTE: 1. May only be claimed when a full 15 minutes has been spent on adhesions. Each subsequent 15 minutes or major portion thereof may be claimed at the rate specified on the Price List.
2. May not be claimed in addition to procedures billed with REDO modifier(s).
3. May not be claimed in addition to HSCs 58.42A, 58.44A, 58.81A, 58.81B, 58.81C and 81.29C.

SECTION OF GENERALISTS IN MENTAL HEALTH

Health Service Code

08.19D Professional interview with relative(s) in connection with the management of a patient with a psychiatric disorder, but without the patient being present during the interview, per 15 minutes or major portion thereof

NOTE: 1. This service is to be claimed using the Personal Health Number of the patient.

2. The relationship of the patient to the person interviewed, must be indicated.

3. The maximum benefit to be claimed by a physician other than a psychiatrist**,** or a pediatrician**, or a generalist mental health** is 2 hours per patient, per benefit year.

SECTION OF INFECTIOUS DISEASES

Health Service Code

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** and vascular surgery (no age restriction).

03.03FA	**SKLL IDIS**	**Replace Base**	**30.00**

SECTION OF INTENSIVE CARE

Health Service Code

13.99EB **Medical Emergency Team Co-ordination by lead physician.....$375.80**

NOTE: 1. Benefit includes patient assessment and necessary interventions including priority attendance, initial stabilization of patient with establishment of peripheral intravenous access, administration of oxygen, insertion of urinary catheter, initiation of appropriate medications and airway control for 'life- threatening' calling criteria.

2. May only be claimed by a Critical Care Specialists whose role is to respond as part of a recognized hospital Rapid Response or Medical Emergency Team when patients fulfill activation criteria and where intervention by physician is required to prevent death or support failing organ systems.

3. After the first full 60 minutes has elapsed, each subsequent 15 minutes or major portion thereof is payable at the rate specified in the price list.

4. May not be claimed in addition to HSC 13.99E.

5. Concurrent claims for overlapping time for the same or different patients may not be claimed.

6. If two claims for HSC 13.99EB at different encounters are submitted by the same or different physician, text is required.

7. Two physicians may not claim HSC 13.99EB or 13.99E for concurrent care on the same day.

SECTION OF NEPHROLOGY

General Rule

GR 4.6.1 Comprehensive visits and/or comprehensive/major consultations may only be claimed once every 180 days per patient by the same physician. Comprehensive visit and consultation services are defined as HSCs 03.04A, 03.08 series, 03.09B, 08.11A, 08.11C, 08.19A and 08.19AA. There must be an interval of 180 days between the first and second comprehensive services. **HSCs 03.04O and 03.04P are defined as comprehensive services and may not be billed more frequently than four times per year as indicated or within 180 days of a comprehensive service or consultation by the same physician.**

Health Service Codes

03.04O Follow-up care of patient with functioning renal transplant – first year.....$251.97
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 for the patient exceed four in the first year following a renal transplant, subsequent visits may be submitted using the appropriate visit HSC.
3. May only be claimed by physicians with NEPH skill code.

03.04P Follow-up care of patient with functioning renal transplant – second and subsequent years.....$161.98
NOTE: 1. May only be claimed 4 times per patient per year 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 visits may be submitted using the appropriate visit HSC.
3. May only be claimed by physicians with NEPH skill code.

03.08I Prolonged endocrinology/ metabolism, gastroenterology, **hematology,** infectious diseases, internal medicine, **nephrology,** physiatry or neurology consultation or visit, full 15 minutes or major portion thereof for the first call when only one call is claimed
NOTE: May only be claimed in addition to HSCs 03.04A, 03.04C, 03.07B and 03.08A when these services exceed 30 minutes.

03.08I	**SKLL NEPH**	**Replace Base**	**$18.00**
	CALL M15		
	1- **6**	For Each Call Pay Base At	100%

SECTION OF NEUROLOGY

Health Service Code

13.59O **Injections of Botulinum A Toxin for the prophylaxis of chronic migraine headaches for eligible patients 18-65 years of age.....$99.90**

NOTE: 1. Eligible patients will have suffered headache activity for greater than 15 days per month with each episode lasting for four or more hours for three consecutive months prior to the initial treatment.

2. Follow up treatment may be claimed in 12 week intervals.

3. Only one call may be claimed regardless of the number of injections performed.

4. May be claimed in addition to a visit or a consultation.

Added to GRs 6.8.4 and 14.2

SECTION OF OBSTETRICS AND GYNECOLOGY

Health Service Codes

10.16B **Pessary removal, adjustment and/or reinsertion $13.00**
NOTE: May not be claimed in addition to HSC 10.16A
Please note, this service is billable in addition to a visit or a consultation. A note will be added to state this in the near future.

11.71A **Removal of intrauterine contraceptive device (IUD).....$13.00**
Please note, this service is billable in addition to a visit or a consultation. A note will be added to state this in the near future.

71.4A
71.4 B
71.4 C
82.64B
82.69B
82.69D
82.7 A
82.64A

These codes have been amended to increase the rate paid for repeat procedures to 200% of the listed rate. Note, you must add modifier REPT in order to receive the increased rate.

3. An additional benefit of 100% may be claimed for a repeat by using modifier REPT.

REPT REPT Y Increase Base To 200%

82.69E **Excision of mesh or graft material (vaginal or abdominal approach) per full 15 minutes $196.82**

83.61 Add BMI modifier to Price List as indicated:

136.37 **BMI BMISRG Y Increase By 25%**

84.21B
84.21C

Delete HSCs from SOMB
Please use new code 84.21D

84.21D **Assisted delivery, forceps, vacuum with or without rotation, mid or lower cavity $130.00**
NOTE: May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.

87.99A **Non-surgical ~~M~~ m**anagement of post partum hemorrhage

87.99AA **Surgical management of severe post partum hemorrhage including but not limited to the use of an intrauterine balloon device or suturing encircling the uterus $149.10**
Added to GR 13.3

SECTION OF OPHTHALMOLOGY

Health Service Codes

03.19A
03.19B Delete

09.02A ~~Initial/repeat complete retinal~~ **Inpatient** examination for retinopathy of prematurity in infants **or non-accidental trauma**
NOTE: May only be claimed for an infant up to one year of age.

09.02D Community or outpatient retinopathy examination of prematurity in infants $107.71
NOTE: May only be claimed for an infant up to one year of age.

09.02E Amblyopia evaluation for patients nine years of age and younger $51.00
Added to GR 9.1.2 and 9.1.3

09.04 Eye examination **under anaesthesia**
~~That which is performed under general anaesthesia~~
Note: May not be claimed when topical anaesthesia only is used.

09.05A ~~Visual fields~~ **Full threshold perimetric examination**, technical

09.05B ~~Full threshold on automated equipment~~ **Full threshold perimetric examination**, interpretation

09.07A
09.07B Delete

09.07C Bilateral dark adaptation study – technical and interpretation $15.43

09.11A **Bilateral** ~~S~~specular microscopy **for corneal graft patients only**, **-** technical

09.11B **Bilateral** ~~S~~specular microscopy **for corneal graft patients only**, **-** interpretation

09.11C Potential acuity measurement **(PAM)** ~~or laser interferometry~~
NOTE: May not be claimed in addition to HSC 09.13G.

09.12A **Intravenous** ~~F~~**fluorescein** angiography **(IVFA)**, interpretation
NOTE: May not be claimed with HSC 13.59C.

09.12B **Intravenous fluorescein angiography (IVFA), technical $157.20**

09.13B Delete

09.13C **Assessment of** serial ~~O~~**o**cular ultrasonography, ~~A mode, for diagnostic and serial~~ measurement**s to evaluate change in tumour dimensions** ~~of intraocular lesions~~
NOTE: Refer to notes following 09.13D for further information.

09.13D Ocular ultrasonography, ~~combined A and B modes~~ for intraocular ~~and orbital~~ pathology**, interpretation**
NOTE: ~~1.~~ HSC**s** ~~09.13B~~, 09.13C and 09.13D may only be claimed by an ophthalmologist.
~~2. A-mode implies a one-dimensional ultrasonic measurement procedure.~~
~~3. Scan B-mode implies a two-dimensional ultrasonic scanning with two-dimensional display.~~

09.13E Optical coherence tomography **(OCT) or equivalent**, interpretation
Please note, this change to add "or equivalent" will <u>not</u> be taking effect on April 1, and will be removed on the October 1, 2014 SOMB.

09.13F Optical coherence tomography **(OCT) or equivalent**, technical
Please note, this change to add "or equivalent" will <u>not</u> be taking effect on April 1, and will be removed on the October 1, 2014 SOMB.

09.13G **Bilateral biometry for cataract surgery, technical $49.16**
NOTE: May only be claimed once every 5 years

09.13H **Bilateral biometry for cataract surgery, interpretation $33.39**
NOTE: May only be claimed once every 5 years

09.16A
09.22A
09.22B Delete
09.24A
09.26B
09.26C

09.26A ~~Provocative tests~~ **Diurnal tension curve**
NOTE: Minimum 4 intraocular pressures separated by a minimum of 2 hours each.

09.26D **Bilateral** corneal pachymetry
Note: 1. May only be claimed once every five years.
2. Billable only in non-refractive conditions. Excludes (Lasik and PRK).

21.0 A
21.13
21.14A
21.2 A

Delete

21.31A Diagnostic irrigation of nasolacrimal duct**, office procedure, per eye**

21.31B Probing **and irrigation** of nasolacrimal duct for patients 18 years of age and under
NOTE: **1.** May only be claimed when performed in an operating room, day surgery or non hospital surgical facility.
2. Benefit rate includes both eyes.

21.32A Delete

21.32C Unilateral probing with intubation of nasolacrimal duct.....$281.86

21.32D Replacement of Jones/bypass lacrimal tube, per eye $225.99

21.42 Snip incision of lacrimal punctum
~~"Three Snip" operation on punctum~~

21.5 Delete

21.69A **Non-surgical c**losure of punctum**, insertion of punctual plugs, per eye**

21.69B Lacerated canaliculi repair
NOTE: Benefit includes intubation.

21.69C Surgical closure of punctum, not punctual plugs, per eye.....$76.84

21.83 Delete

22.4 A ~~Correction of blepharoptosis~~
~~All procedures~~ **Eyelid ptosis repair requiring surgery on eyelid retractors – muller, levator, frontalis and/or lower lid equivalent**

22.5 B **Surgical** ~~T~~**t**arsorrhaphy
Not to be used for botox

22.9 A Delete

22.11A Excision of benign tumor of lid **not requiring pathology analysis**

22.13A Excision of **eyelid lesion requiring pathology analysis** ~~simple lesion(s)~~
NOTE: Single fee applies regardless of whether the upper or lower or both eyelids of same eye are involved. If second eye needs to be done, the fee for the second eye may be claimed at 75%.

22.31
22.32 Delete

22.32A Major full thickness repair of lid involving eyelid margin entropion, ectropion, trauma or tumor.....$451.98

22.39 Delete

22.39A Non full thickness lid procedure for entropion, ectropion or lid repair $309.54
Added to GR 13.3

22.51A Functional blepharoplasty – upper eyelid – without cosmetic intent $384.36
NOTE: May only be claimed for patients 65 years or older.

22.69A Delete

22.69B ~~Lid repair,~~ **Major** full thickness **lid repair** with flap or graft
NOTE: Single fee applies regardless of whether the upper or lower or both eyelids of same eye are involved. If second eye needs to be done, the fee for the second eye may be claimed at 75%.

22.71 Electrosurgical epilation **requiring injection of anesthesia**

24.1 A Peritomy
NOTE: May not be claimed in addition to any other procedure on the same date of service.

24.22A **Conjunctival biopsy or** Removal of simple tumor **excision with pathology analysis**

24.31 Delete

24.31A Reconstruction of conjunctival fornix with graft $903.79

24.32 Delete

24.32A **Other reconstruction of conjunctival fornix $451.98**

24.34A
24.35 Delete

24.35A **Conjunctival flap for corneal ulcer $451.98**

24.39A Delete

24.5 Suture of conjunctiva
NOTE: May not be claimed in addition to other procedures at the same encounter.

24.81 Delete

24.91 Subconjunctival injection
NOTE: 1. May not be claimed in addition to other procedures at the same encounter.
2. May not be claimed for injection of local anaesthetics.

25.1 A Removal of **corneal** foreign body

25.21A Excision of ~~recurrent~~ pterygium ~~and~~ **with** graft

25.29 Delete

25.29A **Excision of pterygium without graft $166.60**
Added to GR 13.3 and 14.1

25.32 Delete

25.39A **Excision of corneal** ~~D~~ **d**ermoid ~~excision~~

25.39D **Phototheraputic keratectomy – for corneal scar, epithelial irregularity or amblyogenic refractive error.....$451.98**
NOTE: May not be claimed for routine refractive purposes.

25.4 A Traumatic ~~C~~corneal wound repair that with sutures ~~or conjunctival flap~~

25.53 Delete

25.53A **Anterior lamellar keratoplasty with graft $903.79**

25.53B **Deep anterior lamellar keratoplasty with graft.....$1355.43**

25.53C **Endothelial keratoplasty $1004.11**

25.55 Delete

25.55A **Penetrating keratoplasty $1255.10**

25.66 Delete

25.81A **Diagnostic corneal scraping $18.12**
Added to GR 9.1.2, 9.1.3 and 13.3

25.92
26.1
26.2 A
Delete

26.2 B Glaucoma implant procedures with reservoir **shunts**

26.25B **Trabeculectomy or major revision of trabeculectomy.....$953.95**

26.29A **Ab-interno angle surgery (stent, trabectome or similar) for adult open-angle glaucoma $461.04**

26.29B **Transcleral drainage of choroidal hemorrhages or subretinal fluid $334.70**

26.34A **Argon laser trabuloplasty, selective laser trubuloplasty, iridoplasty, goniopuncture $409.87**

26.52A **Peripheral iridotomy -** ~~Anterior chamber~~ laser
NOTE: May not be claimed for capsulotomy

26.53 Delete

26.53A **Surgical iridectomy.....$502.14**

26.62A ~~Following penetrating keratoplasty~~ **Freeing of angle closure synechiae under gonioscopy**

26.79A **Scleroplasty/**~~S~~scleral resection

26.91A ~~Paracentesis of cornea~~ **Aspiration or tap of anterior chamber through new wound**

26.91B ~~Irrigation a~~ **A**nterior chamber **washout for hyphema** ~~through corneal incision~~

26.97A Delete

26.97B Placement of radioactive plaque with suturing to sclera.....$813.36

26.98A
27.3 A Delete

27.3 C Yttrium Aluminium Garnet (YAG) laser capsulotomy $204.85

27.4 Delete

27.4 A Intracapsular extraction of lens with or without intraocular lens.....$753.13

27.5 Delete

27.5 B Extracapsular cataract extraction – non phacoemulsification – with or without intraocular lens $753.13

27.7 A **Entry into anterior chamber for manipulation,** ~~R~~repositioning of **lens fragment, IOL or foreign body** ~~pseudophakos with paracentesis~~

27.7 B Delete

27.7 C Remov**e** ~~al~~, replace or repositioning of **subluxed or dislocated intraocular lens (IOL) or secondary insertion of posterior chamber intraocular lens** ~~anteriorly dislocated pseudophakos~~, with ~~secondary~~ **or without** suturing

27.7 E
27.72 Delete – **replace 27.72 with 27.72A**

27.72A Phacoemulsification cataract extraction, anterior approach, with or without insertion of intraocular lens $476.97

27.73 Delete

27.73A Secondary insertion of anterior chamber intraocular lens, includes peripheral iridectomy
.....$662.03
Added to GR 13.3

28.2 D Removal of scleral buckle material.....$677.80
NOTE: May not be claimed with any other procedures at the same encounter.

28.49A Delete

28.5 A ~~Light coagulation or~~ **Posterior segment** ~~cryopexy~~ **or focal or grid laser** ~~(treatment of lesions of retina or choroid)~~

28.5 B **Cryopexy or** ~~L~~**l**aser treatment for retinopathy of prematurity

28.51 Delete

28.54A Panretinal photocoagulation.....$563.55

28.71A ~~Planned a~~ **A**nterior vitrectomy **with port infusion and cutting device**
NOTE: 1. When only procedure performed.
2. For additional fee when performed in conjunction with another procedure - refer to Price List.

28.72B **Posterior** ~~T~~**t**otal vitrectomy **with 2 or 3 port infusion and cutting device**

28.72C Posterior capsulotomy when performed with posterior vitrectomy $102.51

28.73A Pneumatic retinopexy - includes cryopexy, and/or laser, and/or gas injection, and/or paracentesis, and/or fluid drainage $511.54

28.73B Addition or removal of gas or air injection.....$146.13
NOTE: Payable within 60 days following scleral buckling (HSC 28.2 C) or pneumatic retinopexy (HSC 28.73A).

28.74A Delete

28.74B Stripping of premacular membrane associated **with** vitrectomy ~~and retinal encircling~~

28.79B **Intravitreal i**njection ~~or aspiration of vitreous cavity~~ for ~~purposes of diagnosis or~~ drug delivery

28.79C Aspiration of vitreous for diagnostic purposes with or without intravitreal injection for drug delivery.....$231.36
NOTE: May not be claimed for injecting anti Vascular Endothelial Growth Factor (VEGF) medications.

28.81 Delete

28.8 A Eye tumor localization **or planning of plaque placement**

28.81A Biopsy of retina or choroid including intraoperative laser.....$502.14

29.0 A **Orbitotomy - e**xploration and/or biopsy

29.0 B ~~Exploration and~~ **Orbitotomy for** decompression

29.0 C **Orbitotomy - i**ncision and drainage of abscess

29.02A Remove ~~Posterior~~ orbital tumor **posterior to globe – first 90 minutes**

29.09A
29.09B
29.1 A
29.21
Delete

29.21A Evisceration with or without implant.....$903.79

29.31 Delete

29.31A Enucleation with or without implant into tenon's capsule with attachment of extra ocular muscles.....$1129.61

29.39A
29.39B
29.4
Delete

29.4 A Exenteration of orbital contents with or without flap graft.....$1356.60

29.55A Replacement of **socket** implant **or dermal fat graft to socket**

29.81 Delete

SECTION OF ORTHOPEDICS

Health Service Codes

07.54B **Immobilization of hip joint, using splinting device $263.32**
NOTES: 1. For developmental dislocation of the hip in infants.
2. May not be billed in addition to a visit or consultation.

90.40B **Vertical expandable prosthetic titanium rib (VEPTR) surgical insertion for scoliosis or other thoracic deficiency syndrome $3510.99**

90.40C **Vertical expandable prosthetic titanium rib (VEPTR) lengthening procedure $1544.83**

93.24
93.71C
93.87K
93.96B
93.96C

These codes have been amended to include the ORREDO modifier.

SECTION OF OTOLARYNGOLOGY - HEAD AND NECK SURGERY

Health Service Codes

98.51C Delete HSC from SOMB
Please use new codes: 98.51E for head and neck, 98.51F for all other areas

98.51E Free flaps involving microsurgical technique and neuro-vascular hook-up, head and neck reconstruction, full 60 minutes or major portion thereof for the first call when only one call is claimed $455.88

98.51F Free flaps involving microsurgical technique and neuro-vascular hook-up, full 60 minutes or major portion thereof for the first call when only one call is claimed $455.88

SECTION OF PEDIATRICS

Health Service Codes

03.03DG **Complex pediatric hospital visit per full 15 minutes $29.40**

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.

AMA NOTES: *If the total time spent delivering patient care is less than 20 minutes, please bill 03.03D +/- a COINPT modifier if criteria is met. (Please note, the COMX modifier for 03.03D has been deleted, see HIGHLIGHTS portion of Billing Corner for more information). On days where this or any other time based code is submitted, please remember to be compliant with the new GR 2.3.6, see HIGHLIGHTS for more information.*

03.05G Care of healthy newborn in hospital **(first day)**

03.05GA **Care of healthy newborn in hospital (subsequent days).....$40.58**

NOTE: May only be claimed when no other visit service has been provided on that day, regardless of physician.

03.09A Prenatal consultation for fetal assessment

NOTE: 1. May only be claimed by pediatricians (including subspecialties) or by medical geneticists.

2. To be claimed under the maternal number.

~~**3. A major first visit service may not be claimed in the name of the infant within seven days following the prenatal consultation.**~~

SECTION OF PLASTIC SURGERY

Health Service Codes

98.11D
98.11E
98.11F

These codes have been amended to include the RECO CMPRSC modifier.

98.12VA **Laser resurfacing of scars including burn scars, non-functional area, up to 32 total square cms.....$135.73**
NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.

98.12VB **Laser resurfacing of scars including burn scars, non-functional area, over 32 and up to 64 total square cms.....$226.87**
NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.

98.12VC **Laser resurfacing of scars including burn scars, non-functional area, over 64 and up to 100 total square cms.....$352.30**
NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.

98.12VD **Laser resurfacing of scars including burn scars, non-functional area, over 100 total square cms.....$504.20**
NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.

98.12VE **Laser resurfacing of scars including burn scars, functional area, up to 32 total square cms $176.40**
NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.

98.12VF **Laser resurfacing of scars including burn scars, functional area, over 32 and up to 64 total square cms.....$302.32**
NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.

98.12VG **Laser resurfacing of scars including burn scars, functional area, over 64 total square cms $504.20**
NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.

98.13A Melanoma, excision ~~with skin graft~~, excluding face

98.51C Delete HSC from SOMB.
Please use new codes: 98.51E for head and neck, 98.51F for all other areas

98.51E Free flaps involving microsurgical technique and neuro-vascular hook-up, head and neck reconstruction, full 60 minutes or major portion thereof for the first call when only one call is claimed $455.88

98.51F Free flaps involving microsurgical technique and neuro-vascular hook-up, full 60 minutes or major portion thereof for the first call when only one call is claimed $455.88

SECTION OF RESPIRATORY MEDICINE

Health Service Code

02.83B Endobronchial Ultrasonography (EBUS) $162.85

SECTION OF THORACIC SURGERY

Health Service Codes

02.83B **Endobronchial Ultrasonography (EBUS) $162.85**

46.09B **Placement of tunneled pleural catheter $203.57**
Add to GR 13.3

46.09C **Removal of tunneled pleural catheter $115.01**
Add to GRs 6.8.4 and 13.3.

SECTION OF UROLOGY

Health Service Codes

03.03AU Transfer of care of hospital in-patient or out-patient to operating physician

Note: 1. May only be claimed by **general surgery,** orthopedics **and urology**.

2. May only be claimed when a consultation for the patient has already been claimed by another physician of the same specialty.

3. May be claimed in addition to a procedure on the same date of service.

03.03AU	**SKLL UROL**	**Replace Base**	**91.07**

03.03F Repeat office **visit** or scheduled outpatient visit in a regional facility, referred cases only

03.03F	18.72	**SKLL UROL**	**Replace Base**	**49.68**

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** and vascular surgery (no age restriction).

03.03FA	**SKLL UROL**	**Replace Base**	**57.96**

71.96A Extra-corporeal Shock Wave Lithotripsy (ESWL)

Change category code from M to 3

AMA NOTES: *This change allows a consultation (03.08A) to be claimed up to and including the day of the procedure. This change also includes a 7 day pre- and post-operative care period, meaning that in the pre-operative period, regular visits may not be billed as they will be considered to be part of the care required for the procedure. Similarly, in the 7 day post-operative period, any routine visits that are related to the procedure will not be paid. Should complications arise as a result of the procedure, physicians may submit the appropriate visit code with text to briefly explain the post procedures complications. Please remember to check the "text indicator" box for claims that are submitted with text.*

SECTION OF VASCULAR SURGERY

Health Service Codes

50.08A Embolectomy or arteriothrombectomy **of femoral arteries**

50.08AA Embolectomy or arteriothrombectomy of popliteal/tibial arteries $1020.40

50.12C Carotid subclavian reconstruction – any method $1530.60

50.12D Carotid-carotid reconstruction – any method $1530.60

50.34FA Endovascular repair of abdominal aortic aneurysm (Tube graft) $1785.70

50.34GA Endovascular abdominal aortic aneurysm repair (Bifurcated iliac) $3600.00

50.34HA Endovascular repair of ruptured abdominal aortic aneurysm (Tube graft) $2551.00

50.34JA Endovascular repair of ruptured abdominal aortic aneurysm (Bifurcated graft) $3265.28

50.34KA Endovascular repair of aortic arch for aneurysm $3010.18

50.34KB Endovascular repair of aortic arch for ruptured aneurysm, dissection or traumatic injury $4336.70

50.34LA Endovascular repair of thoracic aneurysm for rupture, dissection or traumatic injury $2770.39

51.22 Delete

51.22A Aorta-great vessel bypass – distal anastomosis.....$1785.70
NOTE: If multiple anastomoses are performed, refer to price list.

51.29B
51.49A Delete

51.58A Patch angioplasty – popliteal/tibial artery.....$1147.95

51.58B Patch angioplasty – upper extremity vessel $622.44

51.8 A Resection of carotid body tumor.....$1403.05