

Alberta Medical Association Billing Seminar – Calgary West Central PCN

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Land Acknowledgement

The Alberta Medical Association respectfully acknowledges that we are privileged to live and work on the traditional lands of diverse distinctions-based Indigenous Peoples, including the Anishinaabe (Ah-nish-nah-bey), Dené (De-ne), Nehiyawak (neh-Hee-o-wuk)(Cree), Niistitapi (neeitsee-TAH-peh) (Blackfoot), Otipemisiwak (Oh-tih-pem-soo-wuk) (Métis), Sioux Nakoda (Soo Nakoh-da), Stoney Nakoda (Nakoh-da), Tsuu T'ina (Soot-inna) and more. This land has been gifted with many names including Treaties 6, 7 and 8; the Métis Nation within Alberta, its Otipemisiwak Métis government, the eight Métis settlements and its Métis Settlements General Council and the Homeland of the Métis. The AMA honours the vibrant histories, languages and cultures of the First Nations, Inuit and Métis peoples of Turtle Island, now known as settler Canada, who came before us and continue to thrive here today. We invite everyone to reflect further on how you can contribute to meaningful reconciliation, including actions that move us toward wholistic health for all the relations who host us.

Overview Physician FFS Payments

- Family Medicine office. LTC and Assisted Living billing
- Including
 - Understanding the Schedule
 - What can/can't be claimed
 - Billing Correctly for services
 - Insured vs. Uninsured Services
 - Optimizing your billings
 - Reviews
 - Your review – schedule compliance vs. optimizing billings
 - AH review – schedule compliance

Things to Think About...

- Keep track of what you do, where, and when
 - Write it down; retain your billing records 6 years
- Know when you started and ended your day
 - There's a rule (2.3.6)
- Do your billings frequently so you don't forget what you did
- Pay attention to your reconciliations and rejections – ask if you don't understand
 - Know when a claim is rejected correctly vs. one that can be resubmitted
- Know what's being claimed on your behalf!

Reviewing Claims Results

- Submit your claims and track your assessments against what was claimed
 - Are you being paid in full for your claims?
 - If not, what adjustments are being made?
 - Do you understand why a claim hasn't been paid as submitted?
 - What does the explanatory code tell you?
 - Does it fit with the description, rules and notes related to the code?
 - If not – ask!

Understanding the Schedule

- The Schedule pays for physicians' direct, in person, services to patients, except for:
 - Technical, delegated services (MED 97)
 - Physician to physician, physician to other health provider communications (as described), and team or family conferences
 - Specified phone/other contact with patients, including virtual codes
- Determine the correct health service code – the EMR/billing software description is only part of the story – read:
 - Full description
 - Modifiers
 - Rules
- All other codes may only be claimed when the care is directly, personally provided by the physician

- Claimable delegated services (MED 97):
- 13.42A (allergy injections/sublingual drops given by qualified health professional employed by physician)
 - 13.59A (flu, pneumococcal vaccinations in physician office by qualified professional)
 - COVID vaccination (13.59V)
 - Services provided by physician learner directly supervised by physician (in room, eyes-on)

Not all services can be claimed or have a specific code

- Not every patient-related activity has a specific fee code and may be claimed; some are bundled into other services; others may be part of a service claimed on an earlier date, and no additional claim or time may be added
- For example, the following may not be claimed:
 - Reviewing diagnostic results on a day the patient isn't seen (part of insured basket)
 - Administrative work (practice management, billing, reconciliation)
- The following may be included in visit modifier time, if they occur on the same date as the patient is seen:
 - In-office pregnancy tests or urine dip/urinalysis interpretation
 - Impromptu meetings with members of your care team
- Remember that some codes have specific wording that requires a certain time commitment or that the service be scheduled in advance
- Be sure your billings are consistent with what the Schedule describes and allows; that's your protection in the event of an AH audit
- Don't forget there's a rule requiring you to document time on a day you'll claim a time-based service. Use a convenient method, and track it!

Some Tips

- Physicians – be sure you know what’s being claimed in your name, and how your reconciliations are be handled
 - Don’t allow someone else to be in control of your billings; in an audit you will be held responsible for any errors in billings under your name.
 - Be sure you know what’s being rejected and that rejected and paid at a lower amount claims are being resubmitted when needed
- Alberta Health audits based on a number of factors that can include use of particular codes, referral patterns/claims for consultations, number of hours claimed – if you are audited, call CMPA for legal advice and the AMA for Schedule advice
- Document your patient exam and history taken
- Not every patient care activity has a fee code an may be claimed.
- Ways to avoid audit
 - Bill according to the Schedule and its intent
 - Document what you did – including extent of physical examination and history
 - Don’t claim for overlapping/concurrent time or services; keep track of time worked
 - Questions? contact AMA

Some Tips

- Submitting claims
 - Choose the code that reflects your work (be sure to understand its' intent)
 - If claiming a code that is based on time or requires a certain time commitment, be sure to expend that time
 - Formal, scheduled means that the appointment, team conference or family meeting was booked in advance for that purpose
 - Know (approximately) how long you spent on work related to an individual patient on the date they were seen
 - Be aware of the modifiers that are available for individual codes – they're not all the same
 - Know what modifiers can be used by your specialty – they can be different from other specialties
 - Number of calls:
 - When claiming a time-based code (e.g., 08.19G – psychotherapy, 03.05JB – family conference) indicate the number of time units to be claimed by indicating number of calls
 - Calls is also used for other services claimed in multiples: units of suturing, number of biopsies, etc.
 - Know what services can be claimed together at the same patient encounter

Stay up-to-date

- Read the AMA's Billing Corner and AH Bulletins

- Use the AMA Fee Navigator™

www.albertadoctors.org/feenav



- Download and review the Schedule components:

<http://www.health.alberta.ca/professionals/SOMB.html>

- Remember – Physicians decide what fee code, and how many, to bill!

Need Help?

- Alberta Health Resources
 - [Physician Resource Guide](#)
 - [Schedule of Medical Benefits Procedure List](#)
- Alberta Health
 - Email: Health.HCIPAProviderClaims@gov.ab.ca
- AMA – Physician Advocacy
 - 1-800-272-9680 780 482-2626
 - E-mail: billingadvice@albertadoctors.org



Verifying Coverage

- Netcare/IVR 1-888-422-6257
 - All new patients, those not seen recently, life change (young adult, change in marital status)
 - Check date of coverage and expiry date (patient tab, *more* button)
- Opted out Albertans
 - A few Albertans have formally opted out of health care insurance
 - Bill directly – not limited to Schedule rates
- **Alberta Health does not research patient health numbers**
- **Alberta Health has reinstated Good Faith claims ability – see additional information following**

In office, check eligibility of all new patients, those with life changes, etc. If the patient does not have coverage, offer to move appointment until they have reinstated at local registry, OR charge patient directly at AH rates and provide invoice to allow them to recover from AH.

Patients from Other Provinces/ Territories

- Reciprocal billing
 - All provinces participate except Quebec
 - Bill Quebec patients directly at AB rates
 - Submit claims for all other provinces/territories with patient's home province health insurance number to AH – indicate the province
 - Include patient's address in home province (no punctuation)
 - Is the card in the current format?
 - Check AH's Physician's Resource Guide
 - Check name and DOB against photo ID and scan all OOP health cards

Virtual visits are only claimable for AB patients, and then only when both physician and patient are within provincial boundaries.



Good Faith Claim Requirements

- Document efforts to confirm coverage
- Be sure your billing software provider has re-instated the good faith indicator
 - If not, contact them and request urgent reinstatement
- In addition to usual claim elements, be sure to include:
 - Physician PRACID and Business Arrangement
 - HSC, Modifiers and Diagnostic Code(s)
 - Date of Service
 - Facility Number and Functional Centre
 - Good Faith Indicator field set to “Y”
 - Service Recipient ULI is blank
 - Service Recipient Registration number is blank

Good Faith Claim Requirements

CPD1 Claim Data Segment (Patient Information)

- Patient first and last name (surname)
- Date of birth
- Address including postal code
 - No punctuation
 - Unhoused patients – may use a shelter address
- All information fields are required

Submission Deadlines (GR 2.7.4)

- Since March 31, 2020, claims must be submitted within:
 - 90 days of date of service, or
 - 90 days of date of last communication from AH
- The Minister may give special permission to submit after that, but it's rare:
 - Disasters (fire, flood, employee theft)
 - Infrequent, little/no flexibility

NOTE: Alberta Health deems that they receive a claim on the date it is processed. Alberta Health processes claims on Tuesday, Wednesday and Thursday each week. That means that claims reaching 90 days between Thursday and Tuesday need to be submitted the previous Wednesday to be safely processed.

Time-based Services (GR 2.3.6)

- Physicians must document time spent providing time-based services
- How?
 - Keep track of the start/end of your day each day – retain in chronological order
 - Use a notebook, Excel, app in your electronic device
 - Exclude any time for breaks
 - Include any time you spent after office/clinic hours on work related to patients seen that day
 - Retain for 6 years
- Remember, you may not claim for overlapping or concurrent time

Your EMR or Connect Care may track the time at which individual patients' files are opened and closed, but is not good at tracking when the first was opened and last was closed on a given day.

AMA recommends you track time worked each day separately from your clinic records.

Immunizations

Physicians may claim for COVID-19 vaccinations they or their qualified staff provide to patients in their community offices (13.59V)

- **Covered by AH:**
 - Flu, COVID-19 – physician or nurse (claim 13.59A; no visit unless physician sees and evaluates the patient)
 - Pneumococcal vaccination – may be given by physician or nurse (
 - Tetanus – only for wound management – must be administered by the physician
 - Childhood immunizations – physician administered only
 - Only for preexisting conditions with potential for severe risk of complications
 - For insured vaccinations listed above, claim 13.59A. A visit may only be claimed when those criteria are met
- All other insured injections must be given by the physician
- **Uninsured – may not be claimed from Alberta Health; bill patient directly:**
 - Travel immunizations and associated visits
 - Gardasil
 - Hepatitis

Encounter – Definition (GR 1.14)

- Each separate and distinct time a physician provides services to a patient in a given day (defined as 0001 to 2400)
- Not continuation of an earlier service
- Examples:
 - Visit, sent for Dx (lab, imaging) returns same day = one encounter
 - Visit, treatment initiated, patient returns later same day or physician called to attend by hospital staff, problem worse or new problem = 2nd visit is encounter two
 - Virtual care
 - One virtual care service claimable per day
 - Not claimable same date as in-person service

Diagnostic Coding

- Visits – code for the primary plus – 2 additional fields available if required
- Procedures – require diagnostic codes specific to the reason for the procedure. It's important to be accurate
 - E.g., IUD insertion should be linked to birth control. suturing to traumatic wound, and so on
- Use the linked ICD-9 diagnostic codes – ICD-10 will cause problems

Questions?

Billing Specifics

Visits and Consultations



In-person Visits



Limited/Brief Visits

- The extent of examination of the patient and presenting problem guide which visit or consultation to claim:
 - **Limited Assessment/Visit(03.03A, 03.03AZ) and Limited Consultation** – examination and history focused on the presenting problem (eligible for CMGP modifier)
 - **Minor Consultation (03.07A/AZ) (eligible for CMGP modifier)**
 - NOTE: Consultation requirements (referral, consultant evaluation, formal communication back) must be met and consultant must have a higher-level skill set in treating the patient’s condition
 - **Prenatal Visit (03.03B, 03.03BZ)** – eligible for CMGP modifier
 - **Brief assessment (03.02A)** – minimal history, little or no physical examination (no modifiers).

Consultation referral group includes: Physicians, physiotherapists, dentists, midwives, nurse practitioners in autonomous and independent community practice (i.e., not part of a physician-directed team), dentists. Referring professional must see and evaluate patient before referral.

Complex Care – Family Practice

CMGP	Complex patient consultation/visit – first FULL 15 minutes and then in FULL 10 minute increments to a maximum of 10 units	\$19.54 ea
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- Complex patient requiring that physician spend 15 minutes or more on direct patient care and same-day management of patient care
- Second & subsequent units only billable when **full** 10 minutes has elapsed
- Exclude time claimed under another code (e.g., 13.99BA – pap smear; 03.01LG – physician to physician phone consultation – referring physician)
- Example:
 - 10 minute patient direct contact + 6 minute conversation with diabetic educator + 10 minutes writing referral letter to ortho = 03.03A (office visit) plus CMGP02 modifier
 - Foreign body removal, ear (12.21) = \$49.37 or 03.03A + CMGP = \$58.33 – claim 03.03A with CMGP modifier + 12.21 for the \$13.11 minor tray

Complex Care – Family Practice

Visits and Consultations eligible for CMGP modifier	
03.01J	Assessment of an unrelated condition in association with a Workers' Compensation service (when at same visit, requested by patient)
03.03A 03.03AZ	Limited assessment of a patient's condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient
03.03B 03.03BZ	Prenatal visit
03.03C	Routine post-natal office examination

Complex Care – Family Practice

Visits and Consultations eligible for CMGP modifier	
03.03N	Home visit - first patient
03.03Q	Home Visit – repeat home visit same day
03.03NA	Home visit to patients residing in Assisted Living, Designated Assisted Living (DAL), first patient
03.03NB	Home visit to patients residing in Assisted Living, Designated Assisted Living (DAL), first patient
03.07A 03.07AZ	Minor consultation (only GP skill code) *must fulfil consultation requirements
03.07B	Repeat Consultation (only GP skill code) *must fulfil consultation requirements

Using CMGP Modifiers

- **Definition:** Complex patient visit requiring 15 minutes or more physician time re clinical work (direct, indirect, excluding time)
 - Indirect includes review of diagnostics, charting, drafting referral letter, etc., as long as done on same date as patient visit
- Office visit – 15 minutes (including direct patient time and charting done after clinic hours)
 - 03.03A with modifier CMGP01
- Office Visit – 15 minutes direct patient care; 20 minutes coordinating referral to community support, charting (all same day)
 - 03.03A with modifier CMGP03

Billing Tip:
The full unit of time must elapse to claim a unit of CMGP time – e.g., CMGP01 is claimable at the 15-minute mark, CMGP02 at the 25-minute mark, etc.

Remember to exclude time required for procedures or other services claimed separately and non-physician time.

Comprehensive Visits

- **03.04A (Comprehensive Office Visit); 03.04AZ (Comprehensive Visit, outside of office – e.g., ER, in-hospital outpatient clinic)**
 - Family practice requires complete head-to-toe, all systems exam (GR 4.1)
 - Payable once every 365 days/patient/physician (20-day buffer = 345 days; includes 03.04A/AZ, 03.08A/AZ, CV)
 - Must include a care plan (NEW March 31, 2020)
 - CMXC30 eligible when 30+ minutes, excluding time related to other claimed services/uninsured services
- **03.04B (Comprehensive Prenatal Visit)**
 - Not claimable within 90 days of comprehensive visit
 - Once per pregnancy
 - Includes full history, examination, initiation of prenatal record
 - CMXC30 eligible

Vision testing, hearing testing and related evaluation would be part of the patient evaluation, if performed by the physician.

If a greensleeve form is completed, time on same date may be included in CMX or CMGP modifier time.

Comprehensive Visits

Comprehensive Examination Requirement – Rule 4.1:

In the context of GR 4, complete physical examination shall include examination of each organ system of the body, except in psychiatry, dermatology and the surgical specialties. "Complete physical examination" shall encompass all those organ systems which customarily and usually are the standard complete examination prevailing within the practice of the respective specialty. What is customary and usual may be judged by peer review.

Be sure to document the evaluation of all body systems when claiming a comprehensive patient visit – EMR templates can help

Comprehensive Visits

Comprehensive Visits and Consultations – Rule 4.2.3

Comprehensive Visit: An in-depth evaluation of a patient. This service includes the recording of a complete history and performing a complete physical examination appropriate to the physician's specialty, an appropriate record and advice to the patient. It may include the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient. Advice to the patient must include discussion of a care plan related to the patient's condition(s). Patient care advice, including the discussed care plan, must be documented in the patient's record. The care plan does not have to be formally signed by the patient.

Comprehensive visits must, as of March 30, 2020, include a care plan as part of the discussion with the patient, and this must be documented in the patient record. We suggest a specific set of actions that will be evaluated or followed up at a given time.

New Rule – Comprehensive Visit

- **Comprehensive Visit (Rule 4.2.3) additional requirement, now must include:**
 - “discussion of a care plan related to the patient's condition(s). Patient care advice, including the discussed care plan, must be documented in the patient's record. The care plan does not have to be formally signed by the patient.”
- This new wording impacts requirements for 03.04A
- AH defines care plan as
 - Specific to patient
 - Documented findings and plan for patient with actions/timelines for both
 - Recorded in patient’s record

Complex Care Comprehensive Visits

CMXC30	<p>Complex patient consultation / visit requiring that physician spend 30 minutes or more on patient care and management of patient care (only one claimable) on same date seen</p> <ul style="list-style-type: none">• Include time related to same-day patient care management• Exclude time for services that will be claimed under other health service codes	\$31.59
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Complex Care cont'd

Visits eligible for CMXC30 modifier	
03.04A, AZ	Comprehensive visit
03.04B	Initial prenatal visit

Activities that Contribute to CMX/CMGP

- Complexity is solely determined by time related to care of the individual patient on the date they are seen (No requirement for multisystem disease)
- Services to include in calculation of time when on same date as patient seen:
 - Review of patient chart prior to seeing patient
 - Talking to & examining patient
 - Charting
 - Review of any lab or DI investigations
- Exclude time for another billable service (e.g. 13.99BA) from the calculation of complex visit modifier time
- In case of a consultation, time for dictation of referral or consultation letter may be included
- **NOTE: No non-physician time (including intern/resident/nursing time) may be included**

Home Visits

03.03N	Home visit, first patient seen	\$90.51
03.03P	Home Visit, second and subsequent patients seen	\$40.23
<ul style="list-style-type: none">• Must complete a limited assessment of a patient's condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient to claim• "Home" includes personal residence or temporary lodging, group home, seniors' lodge, personal care home and other residences as approved, but does not include auxiliary hospitals or nursing home• CMGP eligible – include clinical time, charting, care coordination, etc., but not travel time• Eligible for the SUBD modifier for home visits when a call for attendance by the physician has been made AND the physician responds on a priority basis within 24 hours of the call (OFEV, OFEVWK, OFNTPM, OFNTAM).		

Virtual Care Billing Codes



Virtual Care

- **Virtual patient care**
 - Similar to in-person codes, but some differences
 - Must be initiated by patient
 - How? Request for appointment, call to discuss problem, referral for consultation, part of ongoing follow-up care/treatment for illness/condition, etc.
 - Physician may not solicit the visit by cold calling



Virtual Care

- **Time/other requirements**
 - Physician:Patient contact time PLUS same-day patient care management time may be included
 - Be aware of time requirements for each code
 - Start/stop times for direct patient contact **must** be part of detailed patient record; include notes re same-day care management time
 - Must be patient driven (request, previous appointment or consultation request, part of ongoing course of care)

Virtual Care

- Premiums and modifiers
 - More available than initially, but still some restrictions
 - Business Cost and Rural Remote Northern not available
- Limitations
 - May claim only one virtual care or in-person service on the same day; no add'l visit services other than 03.01NM if initiated by pharmacy
 - Not for general information about COVID-19
 - Have a virtual visit followed by in-person on same date?
 - Consider claiming the in-person visit with additional time modifiers to include the earlier virtual encounter.



Virtual Visits

- **03.01AD**
 - <10 minutes direct contact PLUS same-day patient care management time by phone, videoconference, or for a physician's response to a patient email inquiry where advice is given
 - Must be patient-initiated (patient makes appointment or agrees to appointment as part of ongoing follow-up care)
 - Includes prescription renewal or new prescription (no add'l 03.01NM unless pharmacy initiates contact)

NOTE: 03.05JR may be used to follow up by telephone on critical test results requiring action. However, it would not be correct, for example, to call or send an email to a patient regarding test results and claim 03.01AD.

If you are initiating secure email contact with patients, consider 03.01S rather than 03.01AD (may be claimed up to 14/week/physician and not with 03.05JR for same patient, same week)

Advice to Pharmacist

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	\$18.44
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- **Purpose:** To seek advice/opinion or to inform physician when changes to prescription, pharmacist-initiated prescriptions, care plans or med reviews have occurred.
- Pharmacist must initiate
- **Not claimable** for/when:
 - Prescription renewal
 - Physician proxy provides advice
- Max 1/day/patient; multiple patients discussed, each billable
- Visits billable in addition
- Documentation required in patient record

Virtual Visits

- **03.03CV (virtual 03.03A)**
 - 10 + minutes direct contact by phone or videoconference, PLUS same-day patient care management time
 - Limited assessment of problem, advice to patient, record (including direct care start/stop time AND time for care management)
 - Add CMGP01 when total direct and same-day patient care management time is 15+ minutes
 - At this time, there are no additional units of CMGP time available.
 - Document both direct patient contact time PLUS same-day patient care management time in the patient record

NOTE: 03.05JR may be used to follow up by telephone on critical test results requiring action. However, it would not be correct, for example, to send an email to a patient regarding test results and claim 03.01AD.

If you are initiating secure email contact with patients, consider 03.01S rather than 03.01AD (may be claimed up to 14/week/physician and not with 03.05JR for same patient, same week), if other conditions met.

Virtual Mental Health Visits

- **Scheduled telephone/secure videoconference for treatment of psychiatric illness (Family Medicine):**
 - **08.19CW** – Family Med and Pediatrics (per 15 minutes or major portion thereof – **New – October 23, 2023**)
 - Includes medical psychotherapy, medication prescription, reassessment, patient education and/or counseling, including group therapy
 - May also be claimed for direct palliative care and chronic pain care within multi-disciplinary program
 - **Direct physician:patient time only (unchanged October 2023)**
 - Detailed record, including start/stop times is required
 - Not claimable with other virtual/in-person visits same day
 - Patient must have established history requiring service – i.e., a mental health diagnosis made on a date before the 08.19CW is being claimed



Virtual Care Principles

- Billing rules are similar to established rules for in-person visits
- Only physician:patient direct interactions PLUS same-day patient care management time claimable
- Patient-initiated visit can include:
 - A patient-initiated appointment regarding a new problem
 - Consultations and clinically-necessary follow-up of an ongoing condition or previously initiated treatment plan
 - Physician:patient contact following referral by AHS screening program (including COVID-19)



Questions?

Billing Specifics

Other Visits and Patient Care



Psychotherapy (08.19G)

08.19G	Direct contact (in-person) with an individual patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or general psychiatric counseling	\$50.28
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- **NON-PSYCHIATRIST - *only when physician assessment establishes that patient is suffering from psychiatric disorder – for in-person visits, diagnosis may be made on the day the patient is seen***
- Time based; claim per 15 minutes or major portion thereof for last unit (e.g., the 2nd unit of time may only be claimed when 23+ minutes have elapsed)
- Claim for direct physician:patient time only
- Time for patient care coordination not claimable under this code

Admission to Addiction Rx Facility

03.041	Comprehensive visit, including completion of form, required for admission to a regional health authority addiction residential treatment facility	\$130.73
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- Only for AHS-operated facilities
 - See this link:
<http://www.humanservices.alberta.ca/AWonline/IS/4873.html>
- Admission forms to others are uninsured and should be billed to the patient/3rd party

Pre-op H & P

03.04M	Preoperative history & physical in relation to an insured service	\$110.62
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- **NOTE: 03.04M CMXC30 applicable**
 - Included in surgical benefit if same physician provides both
 - **Claimable when an examination and standard form for pre-op assessment have been completed**
 - **Copy must be maintained in patient's chart**
- **Pre-op for dental only insured if anesthetic insured**
 - Severe mental or physical disability precludes performance under local
 - Dental service is insured under dental benefits regulations
 - Presence of disease adds risk to organ transplant or open cardiac surgery or patients with compromised immune system
 - Child 17 or under requires extensive dental rehabilitation (defined as 1 hour or longer; excludes extraction of wisdom teeth & routine treatment (restorative, prosthetic, periodontal, implant procedures, routine extractions)).

Palliative Care

Definition: patient has a terminal illness and is receiving care from a multi-disciplinary team of health and other professionals (GR 4.2.4)

03.05I, 03.05IZ	Direct care	\$54.97
<ul style="list-style-type: none"> • Per 15 min or portion thereof • No current modifiers for after-hours 		
03.05T	Indirect care	\$44.92
<ul style="list-style-type: none"> • Per 15 min or major portion thereof • Essentially a team conference with other physicians, family, allied health, community agencies • Bill under patient ULI 		
03.05U	Second physician at palliative care conference	\$30.17
<ul style="list-style-type: none"> • Per 15 min or major portion thereof 		

NOTE: As of April 1, 2024, 03.05I will be eligible for the SUBD modifier for home visits when the physician sees the patient in their home when a call for attendance by the physician has been made AND the physician responds on a priority basis within 24 hours of the call.

OFEV (weekday, 1700-2200)
 OFNTPM (any day 2200-2400)
 OFNTAM (any day 2400-0700)
 OFEVWK (weekend or stat holiday 0700-2200)

Chronic Pain Care

Definition: “...pain which persists past the normal time of healing, is associated with protracted illness or is a severe symptom of a recurring condition.”

Interdisciplinary chronic pain program: Defined as a comprehensive, coordinated, interdisciplinary program for persons complaining of chronic pain. The interdisciplinary team consists of a medical director; other team members will include psychologist(s) and/or psychiatrist(s), physiotherapist(s) and/or occupational therapist(s) and may include anesthetist(s) and other professional personnel. Treatment is delivered by a coordinated team within the same site by an interdisciplinary chronic pain program.” (GR 4.2.5).

Chronic Pain Care

See previous definition

03.050	Direct management, reassessment, education, and/or general counselling of patient with chronic pain	\$50.28
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- Per 15 min or portion thereof
- Claimable when working within interdisciplinary chronic pain program, OR
- When patient has been assessed at an interdisciplinary program and referred back to home community for ongoing treatment (identify program in patient record)

03.05X	Formal, scheduled professional interview with relative(s) re chronic pain patient, per 15 minutes or major portion thereof	\$54.97
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- Patient must have been assessed in formal program and referred back
- Bill under patient ULI
- Note names/professions of participating individuals
- Claimable when working within interdisciplinary chronic pain program, OR
- When patient has been assessed at an interdisciplinary program and referred back to home community for ongoing treatment (identify program in patient record)

Chronic Pain Care

See previous definition

03.05W	Second/subsequent physician attendance at formal, scheduled professional interview relating to care/treatment of a chronic pain patient (other physicians, and/or direct therapeutic supervision of allied health/community agencies)	\$27.39
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- Per 15 min or major portion thereof
- Patient must have been assessed in formal program and referred back
- Min 30 minutes with medical/paramedical personnel re management of an individual patient's chronic pain
- Claimable when working within interdisciplinary chronic pain program, OR
- When patient has been assessed at an interdisciplinary program and referred back to home community for ongoing treatment (identify program in patient record)

Chronic Pain Care

See previous definition

03.05V	Formal, scheduled professional interview relating to care/treatment of patient with chronic pain with other physicians, and/or direct therapeutic supervision of allied health/community agencies	\$41.99
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- Per 15 min or major portion thereof
- Claimable by physician most responsible for the patient – others use 03.05W
- Min 30 minutes with medical/paramedical personnel re management of an individual patient's chronic pain
- Claimable when working within interdisciplinary chronic pain program, OR
- When patient has been assessed at an interdisciplinary program and referred back to home community for ongoing treatment (identify program in patient record)

Capacity Determination

03.04N	Comprehensive evaluation including completion of forms to determine capacity as defined by the <i>Personal Directives Act (PDA) (RSA 2007 s9(2)(a))</i>	\$204.48
<p>NOTE:</p> <ol style="list-style-type: none">1. Benefit includes witnessing the agents' or service providers' assessment.2. May be claimed to determine lack of capacity or to determine that capacity has been regained. <ul style="list-style-type: none">• See this link for Guide: https://open.alberta.ca/dataset/a86649cc-b0d4-44bb-ab0a-eef8609f29f4/resource/9ff4213f-84b6-4f08-bbcf-05497b5a6017/download/opg-guardianship-publication-opg5630.pdf• See CPSA SOP here: Informed-Consent.pdf (cpsa.ca)• And AP here: AP Informed-Consent-for-Adults.pdf (cpsa.ca)		

Billing Specifics

Telephone/Other Communication with Physicians/Other Professions



Phone Advice

- Phone advice to paramedic, assisted living/designated living and lodge staff, active treatment facility worker (in patient), long term care worker, nurse practitioner, hospice worker, home care worker (in AHS home care program) or public health nurse via telephone or other telecommunication method
 - Different rules for each
 - Resident physicians are not considered active treatment facility staff
 - Claimable for inpatients/LTC patients, but not ER patients
 - Physician **must** be outside the facility to claim

03.01NG	W/D 0700 – 1700	\$18.44
03.01NH	W/D 1700 – 2200 or W/E 0700 – 2200	\$21.79
03.01NI	ANY DAY 2200 – 0700	\$25.14

Claim when instructions re patient care and management are given via telephone at request of facility or home care staff. If call results in physician attending patient in person, claim appropriate visit with time premiums/inconvenience codes or modifiers.

Rules for Phone Advice (03.01NG, NH, NI series)

- Must be initiated by other party
 - Except LTC – may be physician initiated
- Maximum 2/patient/physician/day
- May be claimed in addition to other services SDOS
- Documentation required
- LTC & Active Rx worker – physician must be outside the facility
- Location is where physician is (OTHR, office)
- Nurse practitioner – must be in independent practice or working at nursing station with no physician present
- Home care – may be in person & must be administered by AHS

Physician to Physician Telephone or Telehealth Videoconference or Secure Videoconference Consultation

Referring Physician (must speak with a consultant who is a fully licensed practicing physician – not a resident physician)

03.01LG	W/D 0700 – 1700	\$35.20
03.01LH	W/D 1700 – 2200 or W/E 0700 – 2200	\$38.55
03.01LI	2200 – 0700	\$41.90

Not intended for:

- Hallway consultations (not claimable at all)
- Calls from NPs associated with the practice
- Consultations with physicians within the practice
- Hand-over of patients

Physician to Physician Telephone or Telehealth Videoconference or Secure Videoconference Consultation

- **Claimable** when:
 - Call initiated by referring physician (not resident)
 - Consultant (physician, not resident) provides opinion & recommendations for pat Rx & management
 - Service provided using a secure videoconference system in compliance with CPSA guidelines
 - Physician/clinic has submitted a Privacy Impact Assessment acceptable to the OIPC
- **Not claimable** when purpose of call is to:
 - Arrange for transfer within 24 hours unless patient transferred to an outside facility and advice was given re management prior to the transfer
 - Arrange for an expedited consultation or procedure within 24 hours
 - Arrange for lab or DI investigations
 - Discuss or inform referring physician of results of diagnostic information
- Max 2/day/patient/physician – documentation required
- Telehealth videoconference both physicians must be at regional telehealth facility
- Referral PRACID required

E-Consultations

03.01R	Physician to physician e-consultation – referring physician	\$35.53
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- Time spent completing the referral may **not** be claimed using complexity modifiers
- Documentation of the request and advice given must be recorded in patient record
- Intent is that consultant's review and advice will be commensurate with in-person consultation; not for quick request for advice from a colleague in the same practice or for IM discussion
- **Claimable** when:
 - Request and response are sent using a secure electronic communication that is in compliance with CPSA guidelines on secure electronic communication
 - Physician/clinic has submitted a Privacy Impact Assessment acceptable to the OIPC
- **Not claimable** when/with:
 - Arranging for an expedited consultation
 - Arranging for lab or DI investigations
 - Discussing or informing referring physician of results of diagnostic information
 - For transfer of care
- NetCare eConsultation service eligible

E-Consultations cont'd

03.010	Physician or nurse practitioner to physician secure e-consultation – consultant	\$68.99
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- Requires referral PRACID
- Request and response must be recorded in patient record
- **Claimable** when:
 - Request and response are sent using a secure electronic communication; in compliance with CPSA guidelines
 - Physician/clinic has submitted a Privacy Impact Assessment acceptable to the OIPC
 - Consultant provides opinion/advice &/or recommendations for pt Rx &/or management within 30 days of request
 - Request initiated by referring physician
- **Not claimable** when/with:
 - Major consult, physician to physician phone call, procedure for same condition within 24 hours unless patient transferred to an outside facility and advice was given re management prior to the transfer
 - For transfer of care
 - Arranging for an expedited consultation or procedure within 24 hours
 - Arranging for lab or DI investigations
 - Discussing or informing referring physician of results of diagnostic information
 - For Connect Care or other IM systems

Billing Specifics

Family Conferences/Other
Indirect Services
to/Communication with
Patients



Family Conference via Telephone

03.05JH	Family conference via telephone in regard to a community patient	\$32.68
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- Claimable when:
 - Location or mobility factors preclude meeting in person
 - Communication about patient condition or to obtain collateral information relative to patient management and care activities
 - May be claimed in pre- and post-operative periods
 - Not claimable for relaying lab or DI results or arranging follow up care
 - Documentation of communication to be maintained in patient record

Family Conference via Telephone

03.05JP	Family conference via telephone relating to acute care facility in-patient, registered ER or out-patient, LTC, hospice patient UCC or AAAC patient	\$43.58
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- Intended for patients who are unable to communicate or require periodic family conferences – physician must participate
- Location or mobility factors preclude meeting in person
- Timely communication with family is essential to patient care or organ/tissue transfer/collection
- Communication about patient condition or to obtain collateral information relative to patient management and care activities
- **Not claimable** for relaying lab or DI results or arranging follow up care
- Documentation of communication to be maintained in patient record

Team Conferences

03.05JA	Formal, scheduled, multiple health discipline conference /15 min or major portion thereof	\$44.92
<ul style="list-style-type: none">• With para medical personnel who have independent care responsibilities for the patient re: health care where social & other issues involved (e.g., PT, OT, social worker, etc.)• Not intended for review of physician panel, giving patient care direction to PCN or office staff, including referral coordination, appointment follow-up, meeting with physician-directed team members and so on• Must be booked to discuss specific individual patient, and• Discussion regarding individual patient must be 8 minutes or more to claim• More than one physician attending to discuss individual patient – text required• Max 3 hrs/year/patient/physician (April 1 – March 31)• Not billable at same encounter as visit		

Formal, scheduled means that the conference is scheduled in advance re specific patient. As well, at least 8 minutes must be spent talking about an individual patient to claim for them. Once time is exhausted, can be part of visit complexity time if on same day. Not intended for impromptu meetings throughout day – use CMGP/CMX time.

Physician Call to Patient

03.05JR	Physician telephone call directly to patient, to discuss patient management/diagnostic test results	\$20.00
<ul style="list-style-type: none">• Max 14/week/physician (Sun – Sat)• Claimable for physician-initiated calls to discuss test results or other patient management• May not be used for INR management• Not claimable for same patient in the same calendar week as 03.01S or 03.01T• Physician must speak directly to patient or their guardian• Claimable on same day as 03.03A – use encounters to differentiate• No time-based payment• No additional amount for after-hours calls		

Phone Call – INR

03.01N	Management of anticoagulant therapy	\$18.44
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- 2/month/patient
- Claimable only if advice re: dosage given
- Must be documented
- Includes:
 - Ordering blood tests
 - Interpreting results
 - Adjusting dosage as required
- Not payable for hospital in or outpatients

Procedures

Minor Procedures (M)

Minor Diagnostic Procedures (M+)



Visits with Procedures

- Minor procedure (M) and office visit
 - Both payable only if unrelated reasons/diagnoses
 - Procedure includes removal of sutures
 - Same physician
 - Same practice group
 - Local anesthetic infiltration included in the benefit

If doing an M category procedure that is eligible for a tray fee and visit at same encounter in the physician's office, you may claim the greater of the visit (including modifiers for total time) OR the procedure. If the visit is greater, claim it PLUS the procedure to be paid for the tray fee. AH will pay the full rate for the visit, and the tray fee for the procedure, unless the procedure has the note allowing it to be claimed with a visit. See next page for the list...

Visit & Procedure Exceptions

10.16A	Pessary fitting
10.16B	Pessary removal, adjustment and/or reinsertion (not claimable with 10.16A)
81.8	IUD insertion
11.71A	Removal of intrauterine contraceptive device (IUD)
13.59A	IM or subcutaneous injections (insured injections only) (2 claimable if 2 eligible insured injections at same encounter)
13.590	Injections for Botulinum A Toxin for the prophylaxis of chronic migraine headaches (be aware of age and other requirements)
13.99BA	Periodic Papanicolaou smear
13.99BE	Pelvic examination using a speculum requiring swab(s) and/or sample(s) collection
13.99BD	Anal Papanicolaou smear

These procedures are payable on the same date as a visit if the physician sees and evaluates the patient.

13.59A may be claimed for insured injections given by the physician (excluding local anesthetic), and for flu/pneumococcal vaccinations under the physician's supervision.

The physician must complete and document the evaluation and history required for a visit if it is claimed in addition.

Visit & Procedure Exceptions

These procedures are claimable on the same date as a visit.

16.81A	Spinal tap
51.92A	Varicose vein injection
58.99F	Manual disimpaction of stool
79.22	Cautery of cervix
79.23A	Cryotherapy of cervix
93.91A	Joint injection, hip
93.91B	Joint injection, other joints
98.03A	I&D of abscess or hematoma, subcutaneous or submucous
98.12L	Rx of warts (insured warts only)
98.12C	Removal of sebaceous cyst
98.12J	Removal or excision (warts, keratoses)

13.59A IM/Subcutaneous Injection

Code	Description	Rate
13.59A	IM or subcutaneous injection	\$10.73

- Claimable in addition to visit or consultation at same encounter – exclude procedural time from visit time
- May be claimed for influenza and/or pneumococcal vaccination by qualified member of health team (physician in office at the time). No other injections administered by team members may be claimed using this code.
- Physician visit only claimable if patient seen and evaluated by physician (be aware of individual visit requirements)
- May be claimed by the physician for other insured injections administered by them, not a member of the care team
- Use 13.42A for injection of allergy serum

Injection of Gardasil, travel-related vaccines, hepatitis vaccines are not insured and both the injection and cost of vaccine, if provided by the physician, should be billed to the patient.

13.42A Allergy Desensitization

Code	Description	Rate
13.42A	Desensitization treatments with allergy serums	\$24.14
<ul style="list-style-type: none">• Not claimable in addition to visit or consultation at same encounter• May be claimed for administration of allergy serum or sub lingual drops by qualified member of health team under physician supervision• Maximum of one office visit per month may be claimed for reassessment of patient in lieu of a claim for injection• Includes cost of all materials other than allergy serum• One benefit claim per treatment regardless of number of injections		

Botox Injection for Chronic Migraine

Code	Description	Rate
13.590	Injections of Botulinum A Toxin for prophylaxis of chronic migraine headaches for eligible patients 18-65 years of age	\$100.91

- Claimable in addition to visit or consultation at same encounter – exclude procedural time from visit time
- Patient must suffer headache activity >15 days per month with each episode lasting 4+ hours for 3 consecutive months prior to initial treatment
- Follow-up treatment claimable at 12-week intervals (NOTE – book next visit for injections at 12 weeks + 1 day)
- One call per sitting, regardless of number of injections performed

Injection must be given by the physician to be claimed. The patient may not be charged for additional costs when >1 injection is given. Patients may be charged reasonable costs if the physician provides the Botulinum Toxin for injection – See the CPSA Standard of Practice for information about reasonable costs.

Contraceptive Implant

Code	Description	Rate
98.01A	Implantation of subdermal contraceptive implant	\$63.69
<ul style="list-style-type: none">• Minor procedure; not claimable with visit or consultation for same or related reason on same day• Look at payment for visit/consultation + complexity time vs. that for the procedure and claim the greater.• If claiming the visit in office, also claim the procedure<ul style="list-style-type: none">• AH will pay the visit, AND the tray fee for the procedure, but not the clinical procedure rate		

Contraceptive Implant

Code	Description	Rate
98.04C	Removal of subdermal contraceptive implant (M)	\$55.03
<ul style="list-style-type: none">• Minor procedure; not claimable with visit for same or related reason on same day• Look at payment for visit + complexity time vs. that for the procedure and claim the greater.• If claiming the visit in office, also claim the procedure<ul style="list-style-type: none">• AH will pay the visit, AND the tray fee for the procedure, but not the clinical procedure rate		

IUD Removal

Code	Description	Rate
11.71A	Removal IUD	\$37.24
<ul style="list-style-type: none">• Minor procedure; note allows to be claimed in addition to visit/consult at same encounter• AH will pay the visit, PLUS the procedure, PLUS the tray fee• Eligible for BMIPRO modifier when patient's BMI is 40+		

IUD Insertion

Code	Description	Rate
81.8	Insertion IUD	\$71.48
<ul style="list-style-type: none">• Minor procedure; note allows to be claimed in addition to visit/consult at same encounter• If claiming a consultation, level of examination and history guides whether comprehensive (03.08A) or minor (03.07A) claimable• Eligible for BMIPRO modifier when patient's BMI is 40+		

Pessary Removal/Adjustment/ Reinsertion

Code	Description	Rate
10.16B	Pessary removal, adjustment and/or reinsertion	\$13.47
	<ul style="list-style-type: none">• Minor procedure; note allows to be claimed in addition to visit/consult at same encounter• Not claimable with 10.16A (Pessary fitting)• Minor tray fee payable when done in physician's community office	

Joint Injections

Code	Description	Rate
93.91A	Joint aspiration, injection, hip	\$37.48
93.91B	Joint aspiration, injection, other joints	\$19.98

- Both claimable in addition to a visit or consultation on same day (use same encounter number)
- Second call claimable for a different joint only

Treatment of Warts

- Treatment of warts is uninsured except for:
 - genital warts
 - plantar warts
 - precancerous skin lesions, e.g. actinic keratoses; seborrhoeic keratoses, which are irritated and treatment is medically required
 - warts in immuno-deficient patients
 - immuno-suppressed patients
 - molluscum contagiosum

Treatment of Warts (Insured Only)

<p>NOTE: The following may all be claimed in addition to a visit on the same date – exclude procedure time from visit time when considering modifiers</p>		
98.12J	<p>Removal or excision (warts, keratoses)</p> <ul style="list-style-type: none"> • Maximum of 4 calls claimable – 2+ paid lower 	\$19.23
98.12L	<p>Non-surgical treatment (cryotherapy, chemotherapy) warts or keratoses</p> <ul style="list-style-type: none"> • Only one claimable whether one or many treated (plural wording) 	\$13.84
98.12R	<p>Removal of first plantar wart</p> <ul style="list-style-type: none"> • 2nd at same encounter • 3rd at same encounter <p>Amounts are calculated to fit payment maximum of \$53.58 per encounter</p>	<p>\$36.87</p> <p>\$14.74</p> <p>\$ 1.97</p>

Laceration Repair 98.22A / B

98.22A	Up to 2.5 cm on face, 5 cm on body	\$60.34
98.22B	2 or more calls (i.e. > 5 cm on body) New April 1, 2024 Age modifier L10 – automatic payment at 130% when patient is <10 years of age	\$63.69

- Payment determined by 3 Ls: Length, Location and Layers
- Any method of primary skin closure excluding tape / bandage
- For trauma, not closing a wound resulting from another procedure
- Multiple lacerations – use combined length
- Suture removal included
 - Same physician
 - Same practice group
- Local anesthetic included; major tray fee added when claimed in community office (automatic, based on facility number)

Wedge Resection, Nail

98.96A	Wedge excision, nail (M)	\$63.69
98.96B	Radical excision, nail (6) 30 days pre-op; 14 days post	\$83.80
98.96C	Wedge excision with plastic repair, one side of nail (M)	\$70.39
98.96D	Wedge excision with plastic repair, two sides of nail (M)	\$77.10
98.71D	Vandenbos procedure (1) 0 days pre-op; 14 days post	\$110.62
New	New April 1, 2024	

- None claimable with a visit on the same date for same/related diagnosis
- 98.96B and 98.71D claimable with consultation on same date, including with same/related diagnosis
- All eligible for major tray fee (\$38.98) when done in community office
 - This is an implicit modifier, meaning it pays without you requesting it, based on location

Diagnostic Surgical Procedures (+) (GR 6.6)

- Office
 - “+” and visit – both payable
 - “+” and consultation – both payable
- Hospital
 - “+” and visit – greater only
 - “+” and consultation – both payable

Diagnostic Surgical Procedures

Fee Navigator[®]

Q Search Health Service Codes

Go

Health Service Code 98.81A

Biopsy, skin

NOTE:

A maximum of three calls may be claimed.

Category:	M+ Designated Minor Procedure
Base rate:	\$37.11

Biopsies and Excisions

98.12A	Excisional biopsy, skin (maximum 3) (M+) <ul style="list-style-type: none"> • Each additional biopsy site pays 75% of initial 	\$44.39
98.12B	Excisional biopsy, face (maximum 3) (M+) <ul style="list-style-type: none"> • Each additional pays 75% of initial 	\$56.93
98.12C	Removal sebaceous cyst (maximum 3) (M) <ul style="list-style-type: none"> • Each additional pays 75% of initial • Must be medically required 	\$38.56
98.81A	Biopsy skin (maximum 3) (shave biopsy included) (M+) <ul style="list-style-type: none"> • Each additional pays 75% of initial 	\$38.94
98.81B	Punch Biopsy (M+) <ul style="list-style-type: none"> • Second at same encounter paid 75% of initial • This is different from MOHs surgery which requires special equipment/education/training 	\$20.11

Most biopsies are M+ procedures; billable with a visit at same encounter in community office; exclude time from visit modifier time.

When the maximum stated is 3, that is the total that is payable for that code on that date, regardless of the number of biopsies done. This does not mean that additional biopsies are not insured.

Endometrial Biopsy

NOTE: They may be claimed in addition to a visit on the same date – exclude procedure time from visit time when considering modifiers

80.83B	Endometrial Biopsy (M+) <ul style="list-style-type: none">• Eligible for BMIPRO modifier for patients with BMI of 40+• Minor tray fee paid automatically when in community office	\$45.48
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BMI Modifier (BMIPRO)

- Pays an additional 25% for
 - BMI of 40 or greater or pediatric greater than 97 percentile
 - Applicable to selected procedures provided in any location (including office, ER, etc.), e.g.,
 - 13.99BA – pap smear
 - 13.99BE – pelvic exam using speculum requiring swab(s)/sample(s)
 - Suturing (98.22B) longer lacerations
- Check when providing care to patients with qualifying BMI

NOTE: Suturing codes are not intended for closing defects created through another procedure. E.g., for biopsies, closure of the wound is part of the work paid under the specific code.

Determining How Many Calls Payable

AMA Fee Navigator extract (<https://www.albertadoctors.org/fee-navigator/hsc/98.12K>):

Health Service Code 98.12K

Removal by fulguration, first lesion

NOTE:

A maximum of six calls may be claimed.

Additional notes:

Listed under - Warts or Keratoses:

1. Items 98.12J, 98.12K and 98.12L may only be claimed for the following: genital warts; plantar warts; precancerous skin lesions, e.g., actinic keratoses; seborrhoeic keratoses which are irritated and treatment is medically required; warts in immuno-deficient patients or immuno-suppressed patients; or molluscum contagiosum.
2. The treatment of common warts or keratoses is an uninsured service.

Category:	M Minor Procedure
Base rate:	\$24.15

CALL	NBRSER	1		For Each Call Pay Base At	100%
CALL	NBRSER	2 - 5		For Each Call Increase By	\$6.39
CALL	NBRSER	6 - 6		For Each Call Increase By	\$3.25
CALL	NBRSER			To a Maximum Of	\$52.96

What Does the Number of Calls Mean?

- Number of calls indicates the number of that individual service claimed will pay on a particular date
 - When will AH pay more... if there is no maximum noted
 - How do I claim? Add text
- What if I do more than the maximum number of services?
- AH will not pay, as they have indicated max payable
- Can I bill the patient for the additional ones?
 - No, services above the maximum remain insured, but aren't paid

Diagnostic Surgical Procedures(+) (GR 6.6)

- Office
 - “+” and visit – both payable
 - “+” and consultation – both payable
- Hospital
 - “+” and visit – greater only
 - “+” and consultation – both payable

Assisted Living and Long-Term Care



Assisted Living Visits

03.03NA	Visit to patient residing in Assisted Living, Designated Assisted Living, group home, seniors' lodge, personal care home	\$90.51
03.03NB	Assisted living, DAL, etc., visit, second and subsequent patients seen at same address	\$55.53
<ul style="list-style-type: none">• Maximum of one 03.03NA visit per day, per facility, unless special call for second• Use 03.03NG for second/ subsequent patients seen at same address• Use modifiers (OFEV, OFEVWK, OFNTAM, OFNTPM) only when special call for attendance and physician attends within 24 hours• Use appropriate office visit if room provided to see patients• Physician must complete limited assessment (history and examination, record, advice to patient)		

Long-Term Care

03.03E	Periodic chronic care visit – patient must be seen and evaluated	\$40.23
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- 1/week if no other visit precedes in same calendar week (Sun – Sat)
- 03.03KA, LA, MC & MD + 03.03EA may be claimed subsequent to 03.03E
- Palliative care or intercurrent illness:
 - Bill as 03.03D (daily hospital visits)
 - Use date for admission as the first day of intercurrent illness
 - Eligible for COINPT

Complex Care – LTC

- Complex Modifier for Hospital Inpatients (03.03D):

COINPT	Complex patient care	\$40.61
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- LTC patients with intercurrent illness (03.03D)
- Minimum of 20 minutes management of care
- Not claimable for transfer of care
- One / day / physician

Callbacks to ER, LTC, AACC, UCC

Callbacks – LTC separated into callback & visit		
03.03KA	M-F 0700 – 1700	\$80.45
03.03LA	M-F 1700 – 2200 W/E 0700 – 2200	\$120.68
03.03MC	ANY DAY 2200 – 2400	\$160.90
03.03MD	ANY DAY 2400 – 0700	\$160.90
<ul style="list-style-type: none"> Attend on a priority basis from outside the hospital Special call by staff or another physician Second or subsequent patients at same callback not eligible 		
LTC	Bill in addition to 03.03EA	\$70.39
<ul style="list-style-type: none"> 03.03EA visit to LTC in association with special call back 		
ER, AACC, UCC	Bill in addition to:	
	— 03.03AZ	\$40.23
	— 03.04AZ	\$110.64
<ul style="list-style-type: none"> Subsequent patients at same call – claim 03.02A, 03.03AZ, 03.04AZ 		

Capacity Determination

03.04N	Comprehensive evaluation including completion of forms to determine capacity as defined by the <i>Personal Directives Act (PDA) (RSA 2007 s9(2)(a))</i>	\$204.48
<p>NOTE:</p> <ol style="list-style-type: none">1. Benefit includes witnessing the agents' or service providers' assessment.2. May be claimed to determine lack of capacity or to determine that capacity has been regained. <p>See this link for Guide: https://open.alberta.ca/dataset/a86649cc-b0d4-44bb-ab0a-eef8609f29f4/resource/9ff4213f-84b6-4f08-bbcf-05497b5a6017/download/opg-guardianship-publication-opg5630.pdf</p>		

Pre-op H & P

03.04M	Preoperative history & physical in relation to an insured service	\$110.62
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- **NOTE: 03.04M CMXC30 applicable**
 - Included in surgical benefit if same physician provides both
 - Claimable when an examination and standard form for pre-op assessment have been completed
 - Copy must be maintained in patient's chart
- **Pre-op for dental only insured if anesthetic insured**
 - Severe mental or physical disability precludes performance under local
 - Dental service is insured under dental benefits regulations
 - Presence of disease adds risk to organ transplant or open cardiac surgery or patients with compromised immune system
 - Child 17 or under requires extensive dental rehabilitation

Team Conferences LTC

03.05JD	Formal, scheduled, multiple health discipline conference/5 min	\$15.08
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- Patient in continuing care facility
 - Facility or program as outlined in Continuing Care Health Service Standards is responsible for patient care
- Includes: care planning, care plan review, annual integrated care conference, patient management

Medication Review

03.05JE	Formal, scheduled review of patient medication (multiple patients)	\$15.08
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- Patient in continuing care facility
 - Facility or program as outlined in Continuing Care Health Service Standards is responsible for patient care
- Most responsible physician
- Max of 6 patients/30 min
- Must identify other health professionals involved
- Claimable with other services when provided on SDOS

After Hours Premium Payments

03.01AA

After hours time premium/15 min

- Compensation for time spend outside 0700-1700 weekdays in direct and indirect patient care activities in LTC and active treatment hospitals
 - No fee associated
 - Payable for scheduled & unscheduled services
 - May be physician initiated
 - Direct patient care time related to the provision of an insured service
 - Starts when you start patient care activity not from time of callback

After Hours Premium Payments cont'd

03.01AA	After hours time premium /15 min (hospital only)	
Use with modifiers:		
TEV	W/D 1700 – 2200	\$22.91/15 min
TNTA	Midnight – 0700	\$45.77/15 min
TNTP	2200 – Midnight	\$45.77/15 min
TST	Stat 0700 – 2200	\$45.77/15 min
TWK	W/E 0700 – 2200	\$22.91/15 min
TDES	Designated holiday 0700 – 2200	\$22.91/15 min

- Maximum of four time units /hour/physician
- Bill according to time 15 min period where majority of time spent
- If time covers two time periods, bill each modifier
- If time covers two dates of service (2200 – 0400), need to bill two 03.01AA (one for each date of service)

Time Premium Maximums

- Maximum per day/physician

20	TEV	M – F 1700 - 2200
8	TNTP	2200 – Midnight
28	TNTA	Midnight – 0700
60	TWK	W/E 0700 – 2200
60	TST	STATS 0700 – 2200
60	TDES	Designated holiday 0700 – 2200

Billing Example

1. Callback to LTC patient weekend (30 minutes):
 - 03.05LA + 03.03EA + 03.01AA TWK02
2. Regular LTC visits 5 patients after 5PM weekdays (45 minutes):
 - 03.03E x 5
 - 03.01AA TEV01 for 3 of the 5 patients
 - Why? Only 45 minutes of TEV time claimable, even though 5 patients were seen.
3. Visit to Assisted Living patient, weekday evening, specially called, 25 minutes:
 - 03.05NA + OFEV + CMGP02

WCB Services



Overview

- Legislative authority
- Payment rules
- Monitoring

Legislative Authority

- Section 34 – Report by Physician

“A physician who attends an injured worker shall

a) forward a report to the Board

- i. within 2 days after the date of the physician's first attendance on the worker if the physician considers that the injury to the worker will or is likely to disable the worker for more than the day of the accident or that it may cause complications that may contribute to disablement in the future, and
- ii. at any time when requested by the Board to do so,

Legislative Authority cont'd

- b) advise the Board when, in the physician's opinion, the worker will be or was able to return to work, either in the physician's report referred to in clause (a)(i) or in a separate report forwarded to the Board not later than 3 days after the worker was, in the physician's opinion, so able, and
- c) without charge to the worker, give all reasonable and necessary information, advice and assistance to the worker and the worker's dependants in making a claim for compensation and in furnishing any certificates and proofs that are required in connection with the claim.”

Legislative Authority cont'd

- Section 86 – No charge for medical aid
“No part of the cost of any medical aid provided to or in respect of a worker under this Part is payable by the worker.”

Payment Rules

- **AHW SOMB Rules:**
 - Except for unbundling – defined as:
 - Visit payable with procedure
 - All services paid at 100% - same encounter
 - Exception – where 2nd procedure intrinsically linked to 1st
 - E.g., local infiltration anesthetic with suturing
 - Inclusive care periods do not apply
 - Intravenous sedation with procedures - only if performed by a different physician
 - Cast application billed in addition to fracture
 - Subsequent cast applications within 14 day post operative period – payable

Payment Rules cont'd

- First report defined as the first occasion physician sees patient
- Tray service payment is not automatic
 - Include on invoice (MAJT, MINT)
- BCP payments must be billed to WCB
 - BCP01 for every service provided that is eligible
- One BCP for each visit service including complex modifiers
 - 03.03A CMGP03
 - BCP01 – calls 4

Rejected WCB Claims

- **Why was the claim rejected?**
 - Ineligible profession?
 - Bill AHCIP
 - Determined to be unrelated to work?
 - Bill AHCIP
- **How?**
 - AHCIP will accept outdated claims related to WCB recovery

WCB Report Definitions

- Follow up/progress report:
 - Same day – Report received at WCB on same day as completed examination up to and including 10AM the following business day
 - On time - Report received at WCB within 4 business days of completed examination up to and including 10AM the following business day
 - Late – Not meeting on time

WCB Report Rates

	First Report	Progress Report
Same-Day	\$79.12	\$48.06
On-Time	\$72.10	\$43.80
Late	\$54.08	\$32.86

Closing



Monitoring

- The physician is ultimately responsible for all claims submitted
- Paid does not always mean it was legitimate or correct
- There are some edits in place to catch obvious errors
- Be certain to document your time worked – Connect Care doesn't do that – maintain your own record
- If in doubt, check it out:
billingadvice@albertadoctors.org



Monitoring cont'd

- In the office, compare:
 - Appointments to submissions
 - Submissions to statement of assessment
- Review statement of assessments
- Do explanatory codes make sense?
- If not ask...



Resources



Resources

- **AMA Fee Navigator[®]**
 - www.albertadoctors.org/fee-navigator
- **AMA Billing Advice**
 - billingadvice@albertadoctors.org
- **Alberta Health Bulletins**
 - www.alberta.ca/bulletins-for-health-professionals.aspx
- **Alberta Health Schedule of Medical Benefits**
 - <https://www.alberta.ca/fees-health-professionals.aspx>

Questions & Wrap-up



Thank you!