Medical

Governing Rules List

As Of

01 January 2022

GOVERNING RULES 1

Medical 1

1 DEFINITIONS

This document, entitled the Schedule of Medical Benefits is hereinafter referred to as "Schedule". This Schedule applies only to those services that are insured under the Alberta Health Care Insurance Act. These General Rules (GRs) apply to all benefits unless otherwise stated.

1.1 In this Schedule, "certificate of registration" means a health insurance card issued under the Health Insurance Premiums Act to a resident of Alberta, or any other document prescribed as a "certificate of registration" for the purposes of the Health Insurance Premiums Act and the Medical Benefits Regulation.

1.2 "holidays" or "statutory holidays" means New Year's Day, Family Day, Good Friday, Victoria Day, Canada Day, Alberta Heritage Day, Labour Day, Thanksgiving Day, Remembrance Day, Christmas Day, Boxing Day;

1.3 where a holiday falls on a Saturday or Sunday the Minister shall designate another day as the holiday;

1.4 "physician" includes "osteopath";

1.5 "benefit year" means July 01 of one year to June 30 of the following year.

1.6 For the purposes of billing home visits, "home" includes personal residence or temporary lodging, assisted living, designated assisted living, group home, seniors' lodge, personal care home and other residences as approved, but does not include auxiliary hospitals or nursing homes.

1.7 A physician's "family" means children, grandchildren, siblings, parents, grandparents, spouse or adult interdependent partner or any person who is dependent on the practitioner for support in accordance with the Alberta Health Care Insurance Regulation.

1.7.1 A patient's "family" means children, siblings, parents, legal guardian/agent (agent as defined in the Personal Directives Act (RSA 2007c37s3)), spouse or adult interdependent partner.

1.8 "Home Care Worker" is defined as a registered: nurse, licensed practical nurse, psychiatric nurse, occupational therapist, physiotherapist, respiratory therapist, or any other health profession working in an Alberta home care program or Alberta palliative care program administered by a regional health authority.

1.9 "Community Mental Health Care Worker" is defined as a registered: nurse, licensed practical nurse, psychiatric nurse, social worker, psychologist or any other health profession working in an Alberta community mental health care program administered by a regional health authority.

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.

1.11 "Videotechnology" means the recording, reproducing and broadcasting of visual images.

1.12 "Store and forward" is defined as a system that provides the ability to capture and store text, audio, static and video images and forward them for the review and opinion of a physician.

1.13 "Rotation Duty" means
- scheduled hospital emergency department duty providing on-site emergency department physician coverage or physicians providing first call coverage for an emergency department with greater than 25,000 visits per year or;
- scheduled on-site coverage in a facility designated by Alberta Health as an AACC or UCC.

1.14 Unless otherwise stated, the term "encounter" used in this Schedule means each separate and distinct time a physician provides services to a patient in a given day as defined in GR 1.19. To be recorded as separate encounters, multiple services provided to a patient may not be initiated by the physician, or may not be a continuation of a service which began earlier in the day. An example of continuation of services is the time spent with a patient to review x-ray or laboratory results ordered during an examination of the patient earlier in the day. If the patient initiates the second and subsequent encounter(s) or the physician is requested to attend the patient by hospital or nursing home staff, additional encounters may be claimed.

1.15 "Conceptual age" is defined as the estimated gestational age from the actual time of conception. It is usually considered to be at least 14 days after the first day of the last menstrual period.

1.16 "Neonate" is defined as a newborn infant up to and including 30 days of age.

1.17 "Resident of Alberta" means a person lawfully entitled to be or to remain in Canada, who makes the person's home and is ordinarily present in Alberta and any other person deemed by the AHCIP regulations to be a resident, but does not include a tourist, transient or visitor to Alberta.

1.18 "Home visit" means a visit by a physician to provide care for a patient in their home.

1.19 "Day" means a period of 24 hours starting at midnight.

1.20 "Medical learner" means a supervised physician in training.

1.21 "HSC" means Health Service Code.

1.22 "AACC" means Advanced Ambulatory Care Centre.

1.23 "UCC" means Urgent Care Centre.

1.24 "CPSA" means College of Physicians and Surgeons of Alberta.

1.25 "Corrected age" means the chronological age reduced by the number of weeks born before 40 weeks of gestation.

1.26 Telecommunications means communication via telephone, facsimile or email.

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.

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

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

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

1.31 "Active Practice" is defined as a physician that has fulfilled both of the following criteria in the previous 12 months:
a) 5 or more procedures where the physician is acting as the primary surgeon AND
b) the physician has submitted claims and provided at least 10 or more of either or any combination of the following HSCs: 03.03A, 03.03AZ, 03.07A, 03.07AZ, 03.07B, 03.08A or 03.08AZ.

1.32 "Mobile Integrated Healthcare Unit Paramedic" is defined as a registered paramedic who is a member of and providing services for Alberta Health Services' Mobile Integrated Healthcare Unit

1.33 An "in office" service is defined as a service that is not provided in the following publically funded facility types: Active Treatment Centre, Ambulatory Care Centre, Auxiliary Hospital, Health Canada Nursing Station, Community Ambulatory Care Centre, Community Mental Health Clinic, Nursing Home, Regional Contracted Practitioner Office and Subacute Auxiliary Hospitals. The following Health Service Codes are designated as "in office": 03.03A, 03.03B, 03.03F, 03.04A, 03.05I, 03.07A, 03.08A, 03.08B, 03.08I, 03.08J, 08.19A, 08.19G, 08.19GA, and 08.45.

An "out of office" service is defined as a service that is provided in the following publically funded facility types: Active Treatment Centre, Ambulatory Care Centre, Auxiliary Hospital, Health Canada Nursing Station, Community Ambulatory Care Centre, Community Mental Health Clinic, Nursing Home, Regional Contracted Practitioner Office and Subacute Auxiliary Hospitals. The following Health Service Codes are designated as "out of office": 03.03AZ, 03.03BZ, 03.03FZ, 03.04AZ 03.05IZ, 03.07AZ, 03.08AZ, 03.08BZ, 03.08IZ, 03.08JZ, 08.19AZ, 08.19GZ, and 08.45Z

2 APPLICATIONS

2.1 The benefits payable for services provided inside or outside Alberta by or under the supervision of a physician, shall be the benefit prescribed in the Schedule subject to GRs outlined herein.

2.2 Where a specific case contradicts a general statement within these GRs the specific shall override the general statement.

2.3 Claims for unlisted services will be assessed by comparing the service provided and the fee claimed with similar or comparable services listed in the Schedule. The assessment will be based on the time, complexity, and intensity of the services. Supporting information, such as an operative report, is required with the claim.

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.

2.3.2 Cumulative time is calculated by adding the total time spent delivering patient care as identified in the description of the HSC, over the course of the day (GR 1.19) and dividing the total time by the time units specified in the HSC to determine the appropriate number of calls. When the remainder of the time calculation equals less than half of one call, an additional call may not be claimed. Separate encounters may only be claimed when a special call for attendance has been made on the patient's behalf.

2.3.3 Where time is described as a full amount of minutes e.g. a full 5 minutes, the physician must spend the full amount of time stated in the HSC in order to submit a claim for the service.

2.3.4 Where time is described as a portion thereof, the physician may spend any amount of time providing the services described by the HSC in order to submit a claim for the service.

2.3.5 Where time is described as a major portion thereof, the physician must spend a minimum of half of the time described in the HSC providing the service in order to submit a claim for the service. Additional calls for the same HSC may not be claimed until the full time period as described in the HSC for each previous call has elapsed.

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.

2.3.7 Concurrent billing for overlapping time for separate patient encounters/ services may not be claimed.

2.4 SPECIALIST

2.4.1 Specialist benefit rates may be claimed only by a physician who has received a specialist certificate in accordance with the Medical Profession Act.

2.4.2 An interim certificate issued by the CPSA will be accepted in lieu of a formal certificate where a physician has completed the requirements for a specialist certificate and is awaiting formal recognition.

2.4.3 Physicians that are recognized as having more than one specialty designation from the CPSA shall use the skill code appropriate to the services they are providing or for which the referral was requested.

2.5 CATEGORY CODES

2.5.1 All HSCs in this Schedule are assigned a category code as follows:

C - Anesthetic
R - Surgical Assist
V - Visit
T - Test
M - Minor Procedure
M+ - Designated Minor Procedure
1, 3, 4, 6, 14, 15 - Major Procedure

2.5.2 Unless otherwise specified in this Schedule, HSCs designated with a T category code may be claimed with visits and consultations on the same day.

2.6 Variations in Payments

Benefits may be claimed in excess of those listed in the Schedule for services involving unusual complications or care. Requests for increased compensation require additional documentation, either an operative report or other detailed description of the care to support the claim.

2.7 CLAIMS FOR BENEFITS

2.7.1 A claim must be submitted in the format prescribed by the Minister.

2.7.2 GR 2.7.1 applies whether the claim is submitted by a physician on behalf of a patient or by the patient.

2.7.3 For administrative purposes the start of the day is considered to be midnight. A hospital visit which takes place after 0700 hours may be claimed in addition to one of the following services provided between midnight and 0700 hours:

a) emergency home visit and admission to a hospital and hospital visit on the same day;
b) home visit;
c) hospital admission or consultation claimed in lieu of hospital admission;
d) emergency visit/special callback to hospital emergency/outpatient department, AACC or UCC, when specially called from home or office;
e) a special call for attendance to a patient at a closed office, with no staff in attendance.

2.7.4 Unless the Minister considers that extenuating circumstances exist a claim for benefits is payable subject to the timelines indicated in the Alberta Health Care Insurance Act and regulations.

2.7.5 Claims may be submitted by a physician who is present and supervising a resident or intern during the provision of a service.

2.8 TEAM CONFERENCES

2.8.1 Team conferences related to the care and treatment of a patient with other physician(s), allied health professionals, educational, correctional, and other community agencies may be claimed if provided via telephone or secure videoconference. Such services include 03.05JA, 03.05JD, 03.05JJ, 03.05JM, 03.05JN, 03.05T, 03.05U, 03.05V, 03.05W, 03.05Y, 03.05YM, 08.19F, 08.19H, 08.19J, and 08.19K.

3 EXCLUSIONS

3.1 The following includes examples of, but is not limited to, services which are not a benefit under the Schedule and may not be claimed:

a) Advice by telephone or other telecommunication methods except as specified under specific HSCs or for telehealth services;
b) Ambulance services, except ambulance detention time HSCs 13.99K, 13.99KA, 13.99KB;
c) Anesthetic materials;
d) Any service a physician provides to his/her children, grandchildren, siblings, parents, grandparents, spouse or adult interdependent partner or any person who is dependent on the practitioner for support in accordance with the Alberta Health Care Insurance Regulation;
e) Drugs/agents;
f) Intravenous sedation for dental procedures administered to a patient who is not an inpatient or registered outpatient of a hospital;
g) Medical appliances;
h) Medical testimony in court, except psychiatric opinion at psychiatric review panel under the Mental Health Act;
i) Secretarial or reporting fees;
j) Stand-by time;
k) Travel time of a practitioner to see a patient;
l) Services requested or required by a third party. Examples include but are not limited to:
   - Examinations or certification related to adoption;
   - Medical examinations to indicate fitness to attend camp;
   - Autopsies;
   - Employment examinations and reports;
   - Examinations and reports requested under the auspices of the Child Welfare Act;
   - Immigration requirements;
   - Insurance/disability reports and forms;
   - Examinations and reports for judicial purposes (e.g., requested by police);
   - Medical-legal reports requested by patients or by lawyers on behalf of patients with the exception of HSC 03.01MT;
   - Motor vehicle license;
   - Examinations and forms relating to participation in sports;
   - Examinations and forms relating to university or other school requirements;
   - Passport and visa applications;
m) Pre-travel assessments, counseling or administration of vaccines or drugs for travel purposes to reduce the patient's risk of acquiring an illness, or for prevention of communicable diseases not endemic to Canada;
n) Administration of vaccines such as Hepatitis A and B is not covered unless specifically otherwise communicated by Alberta Health.

3.2 Benefits may not be claimed by a surgeon, surgical assistant or anesthetist with respect to:

a) a procedure performed for cosmetic reasons;

b) a surgical procedure for the alteration of appearance performed for emotional, psychological or psychiatric reasons unless the Minister gives approval prior to the surgery being performed. Supporting documentation reflecting the need for the change must be retained by the physician.

3.3 Except for services known to be uninsured, the initial visit(s) to establish a diagnosis of the patient's condition is an insured service, including situations where the patient has been referred to another physician. After establishing a diagnosis during the initial visit(s), if the physician determines the service is not medically required, or is an uninsured service, all subsequent services related to the uninsured service such as preoperative tests, assessments, consultations, surgical procedures, anesthetic or surgical assists may not be claimed.

3.4 Uninsured services may not be claimed. Examples of uninsured services include but are not limited to:

- Services, including procedures, which are not medically required;
- Acupuncture;
- Artificial insemination;
- Chelation therapy which is not provided to a hospital inpatient for the purpose of treating lead poisoning;
- Eye surgery intended for the sole purpose of eliminating the need for eyeglasses or contact lenses;
- Gamete intrafallopian transfer;
- In vitro fertilization;
- Ovarian stimulation and monitoring in association with assisted reproductive technologies;
- Sperm transfer;
- Cosmetic liposuction;
- Breast enlargement for purposes other than specifically listed in the schedule;
- Oculo-visual examinations for residents aged 19 through 64 years.

3.5 Deleted

3.6 Deleted

3.7 Deleted

4 VISITS AND CONSULTATIONS

4.1 COMPLETE EXAMINATION - DEFINITION:

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.

4.2 VISITS - DEFINITIONS

4.2.1 Brief Visit: Assessment of a patient's condition when history is minimal and little or no physical examination is included.

4.2.2 Limited Visit: A limited assessment, of a patient, which includes a history limited to and related to the presenting problem, and an examination which is limited to relevant body systems, an appropriate record, and advice to the patient. It includes the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient.

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.

4.2.4 Palliative Care: Defined as care given to a patient with a terminal disease such as cancer, AIDS or advanced neurologic disease. Palliative care involves active ongoing multi-disciplinary team care. Physicians involved in palliative care may claim for services provided under 03.05I, 03.05IZ, 03.05T and 03.05U as applicable.

4.2.5 Chronic Pain: Defined as 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.

4.2.6 Deleted

4.2.7 Comprehensive Visit in Emergency Department, AACC or UCC:
An in-depth evaluation of a patient with a new or existing medical condition, including the recording of a complete history and a complete physical examination, and, where required, the ordering and reviewing of laboratory tests and x-rays and the initiation of appropriate therapy. May also be claimed for those patients whose illness or injury requires prolonged observation, continuous therapy and/or multiple reassessment(s) or for patients presenting with obstetrical problems or gynecological bleeding who require an internal examination. May be claimed by emergency medicine physicians, full-time emergency room physicians, general practitioners and pediatricians working a rotation duty shift in an emergency department with 24 hour on-site physician coverage or in an AACC or UCC with on-site coverage.

4.2.8 Deleted

4.3 CONSULTATIONS - DEFINITIONS

4.3.1 Comprehensive Consultation: An in-depth evaluation of a patient with a written report to the referring physician, audiologist, Alberta registered midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner. This service includes the recording of a complete history, 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 and/or the referring physician, audiologist, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner.

4.3.2 Limited Consultation: Limited assessment of a patient and a written report to the referring physician, audiologist, Alberta registered midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner. A limited consultation includes a history limited to and related to the presenting problem, and an examination which is limited to relevant body systems, 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 and/or the referring physician, audiologist, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner.

4.3.3 Time Based Consultations: Notwithstanding GRs 4.3.1 and 4.3.2, claims for consultation services as defined under HSCs 03.08F, 03.08I, 03.08IZ, 03.08J, 03.08JZ, 03.08L, 03.08M, 08.19A, 08.19AZ, 08.19AA, 08.19B, 08.19BB, 08.19C, 08.19CC, and 08.19CX may be claimed on a time basis.

4.3.4 Psychiatric Consultation referred by other professions: A benefit for a psychiatric consultation (HSCs 08.19AA, 08.19BB, 08.19CC) may be claimed when a patient is referred to a psychiatrist by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist and the provisions that apply to consultations under GRs 4.3, 4.4 and 4.6 are met.

4.4 CONSULTATION - APPLICATION

4.4.1 In this Schedule "consultation" means that situation where a physician, audiologist, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner after an appropriate examination of the patient, requests the opinion of a consultant physician, and the consultant does a history, an examination and a review of the diagnostic data and provides a written opinion with recommendations as to the treatment, to the referring physician, audiologist, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner. Consultations may not be claimed for the transfer of care alone.

4.4.2 The need for a consultation can arise as a result of the following:
a) some unusual or serious clinical problem,
b) a physician, audiologist, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner requires further advice regarding diagnosis or management or both, or
c) the patient, parent or guardian requests another opinion.

4.4.3 A referral may be accepted from any person; however, to receive reimbursement as a consultation, a request must be made by the referring physician, audiologist, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner to the consultant in the form of:

a) verbal or written communication (fax, email, letter);
b) verbal or written communication between an agent representing the referring physician, audiologist, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner and the consultant;
c) verbal or written communication between the referring physician, audiologist, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner and an agent representing the consultant;
d) verbal or written communication between agents representing the referring physician, audiologist, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner and the consultant.

Agent means any of the following individuals who are acting under the direction of the referring physician, audiologist, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner and the consultant, as appropriate:

a) an employee of a physician, audiologist, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner; or
b) a hospital or long term care facility staff member; or
c) a supervised physician in training acting under the direction of a physician.

Payment for a consultation to an Alberta physician may also be made when an Out of Province physician refers the patient and the criteria stated herein are met.

4.4.4 If a consultation is followed by a procedure performed by the consultant, a benefit may be claimed for the consultation as well as a major procedure up to and including the day of surgery.

4.4.5 A benefit for continuing care may be claimed by a consultant following a consultation where the continuing care is provided at the request of the referring physician, audiologist, chiropractor, midwife, podiatrist, dentist, optometrist, physical therapist or nurse practitioner.

4.4.6 Repeat consultations may not be claimed unless a further request has been initiated by and received from the referring physician, audiologist, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner for another consultation. A repeat consultation may not be claimed if initiated by the consultant.

4.4.7 When a physician sends a member of his family to another physician, a consultation benefit may not be claimed.

4.4.8 CLAIMS REQUIRING REFERRING PRACTITIONER NUMBER

When a claim is submitted for the following HSCs, the referring practitioner field must be completed with a valid referring practitioner number.

HSCs in the following list marked with an asterisk(*) cannot be self-referred. Self-referred means the physician is providing the diagnostic service and treating the patient.

HSCs in Section E (Lab and Pathology) and X (Diagnostic Radiology) require a valid referring practitioner number with the following exceptions:
HSC X27D does not require a referral and HSC X27F may be self-referred.
HSC 03.03D requires a valid referring physician, chiropractor, midwife, podiatrist, dentist, optometrist, physical therapist or nurse practitioner number when it is a visit to a referred patient.

01.01A	01.01B	01.03	01.04A	01.05A	01.09
01.12A	01.12B	01.14	01.16A	01.16B	01.16C
01.22	01.22A	01.22B	01.22C	01.24A	01.24B
01.24BA	01.24BB	01.32	01.34	02.82A	02.84A
02.84B					
*03.01O	*03.01LJ	*03.01LK	*03.01LL	*03.03D	*03.03F
*03.03FA	*03.03FV	*03.03FZ	*03.04Q	*03.05B	*03.07A
*03.07AZ	*03.07B	*03.07C	*03.08A	*03.08AZ	*03.08B
*03.08BZ	*03.08C	*03.08CV	*03.08F	*03.08H	*03.08K
*03.08L	*03.08M				
*03.09A	*03.09B	03.12A	03.16A	03.16B	03.16C
03.16D	03.19C	03.19D	03.21A	03.22A	03.22B
03.22C	03.26	03.29A	03.37A	03.37B	03.38A
03.38B	03.38C	03.38D	03.38E	03.38F	03.38G
03.38H	03.38K	03.38M	03.38N	03.38P	03.38R
03.38S	03.38T	03.38X	03.41A	03.41B	03.41C
03.41D	03.44A	03.45A	03.45B	03.52A	03.52B
03.52C	03.52D	03.55A	03.55B	03.56A	03.56B
07.09A	07.09B	*08.19A	*08.19AZ	*08.19B	*08.19C
*08.19AA	*08.19BB	*08.19CC	*08.19CX	09.01A	09.01B
09.01C	09.01E	09.02B	09.02E	09.05A	09.05B
09.06A	09.07C	09.11A	09.11B	09.11C	09.12A
09.12B	09.13C	09.13D	09.13E	09.13F	09.13G
09.13H	09.23A	09.23B	09.24B	09.26A	09.26D
09.41A	09.41B	09.43A	09.43B	09.43C	09.43D
09.43E	09.46A	09.49A			
10.04	10.08A	10.33B	13.99CC	*13.99GA	14.49A
14.82	14.85B	14.88A	14.88B	15.94A	16.83A
16.83B	16.83C	16.89A	16.92B	17.81B	19.81
22.81	24.89A	24.89B	28.8 A	28.81A	29.0 A
30.81A	33.22B	37.81	37.82A	37.82B	38.89A
38.89B	39.21A	39.62A	39.83A		
40.92A	41.29A	41.29B	42.09B	43.81	43.82
44.3 B	45.81A	45.83	45.84B	45.86A	46.5 A
46.81A	46.82	46.84A	46.88A	48.92A	48.98A
48.98B	49.93A	49.95A	49.96A	49.96B	49.98B
49.98C	49.98D				
50.81A	50.81B	50.81C	50.81D	50.81E	50.82A

50.82B	50.83A	50.84A	50.84B	50.84C	50.87A
50.87B	50.87C	50.88A	50.89A	50.89B	50.89C
50.89D	50.89E	50.91B	50.95A	50.95B	50.98A
52.1 A	52.11A	52.12	52.13	52.85A	53.81A
53.81B	53.83A	54.89A	54.89B	54.89D	54.89E
54.89F	57.92A				
60.82C	60.89A	62.12A	62.12B	62.81A	63.86A
63.96B	64.95A	64.97A	66.19A	66.3 C	66.83
66.89A	66.89B	66.89C	67.81	67.86	67.87A
67.89A	68.95	69.83A	69.83B	72.91	72.92A
74.82A	75.83A	76.89A	78.7 A	79.29E	
80.81	80.83B	80.85A	80.85B	82.12A	82.81A
82.91A	83.7 A	87.53A	87.53B	87.54A	87.55A
89.59A	89.59B	89.59G	89.98A	92.70	92.71
92.72	92.74	92.75	92.76	92.78A	92.78B
92.78C	92.8 A	92.8 B	95.81A	97.11A	97.11B
97.81	97.82A	97.83A	97.89A	97.89B	98.12A
98.12B	98.8 A	98.81A	98.81B	98.89A	98.89B
98.89C	98.89D	98.89E	98.89F	98.89G	98.89H
F7					

4.5 CONSULTATION: PHYSICIANS ON ROTATION IN THE EMERGENCY DEPARTMENT/AACC/UCC

4.5.1 A physician on rotation duty in the emergency department or in an AACC or UCC may claim a comprehensive consultation when the conditions in GR 4.3 have been met.

a) Deleted
b) Deleted

4.5.2 A limited consultation may be claimed when dealing with one particular problem and shall include interpretation of laboratory tests, and a written report to the referring physician, audiologist, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner who must care for the patient in the future. A claim for a limited consultation may be made when there is a written request or other documented communication from the referring physician, audiologist, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist, nurse

practitioner or their agent for an opinion or treatment by the emergency physician.

4.6 LIMITATION ON VISITS AND CONSULTATION DESCRIBED AS COMPREHENSIVE

4.6.1 Comprehensive visits and/or comprehensive/major consultations may only be claimed once every 365 days per patient by the same physician. Comprehensive visit and consultation services are defined as HSCs 03.04A, 03.04AZ, 03.08A, 03.08AZ, 03.08B, 03.08BZ, 03.08C, 03.08CV, 03.08F, 03.08H, 03.08K, 08.11A, 08.11C, 08.19A, 08.19AZ, 08.19AA, and 08.19CX.

HSC 03.09B is defined as comprehensive and may not be billed more frequently than once every 180 days by the same physician.

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.

4.6.2 Notwithstanding GR 4.6.1, 03.08A, 03.08AZ, and 03.08CV may only be claimed for patients under 12 months of age once every 90 days per patient by the same physician. There must be an interval of 90 days between the first and second consultation.

4.6.3 Notwithstanding GR 4.6.1, an initial prenatal examination 03.04B may not be claimed within 90 days of another comprehensive visit or consultation. Comprehensive visit and consultation services are defined under GR 4.6.1. There must be an interval of 90 days between the first and second services.

4.7 OTHER LIMITATIONS ON VISIT ITEMS

In general, when an office visit and a hospital admission are provided to a patient on the same day by the same physician, only the greater benefit may be claimed. There are two exceptions to this. Firstly, if a new condition arose and the patient was seen at two separate encounters, both services may be claimed. Information must accompany this claim. Secondly, two services may be claimed when they fall within the provisions of GR 2.7.3.

4.8 CONCURRENT CARE IN HOSPITAL

4.8.1 If the services of more than one physician are required because of the complexity of the clinical needs of a patient, each physician may claim a benefit for concurrent care. Satisfactory supporting information must accompany the claim.

4.8.2 If a consultation is required, the attending physician and the consultant may each claim for services provided on the day of consultation.

4.8.3 If the provisions of GR 4.4.5 apply, a benefit may be claimed by the referring physician only after the full responsibility for the care of the patient has been returned to him/her, or the complexity of the clinical needs of the patient require the services of the referring physician in addition to those of the consultant.

4.8.4 When the care of the patient remains with the referring physician, audiologist, midwife, chiropractor, podiatrist, dentist, physical therapist or nurse practitioner and the nature of the illness makes further intermittent visits by the consultant advisable, they may not be claimed as repeat consultations.

4.9 SUPPORTIVE CARE

4.9.1 When a patient is in hospital under a specialist's care, and the family physician or pediatrician is not actively managing the case, the family physician or pediatrician may claim supportive care benefits (03.05M, 03.05MA). The following criteria apply:

a) deleted
b) the patient, the patient's family or the most responsible physician specifically requests that the family physician or pediatrician visit for the purposes of liaison or reassurance.

4.9.2 If medical complications develop or are present which require active management by the family physician, hospital visits should be claimed in accordance with GR 4.8.

4.10 TRANSFER OF CARE

4.10.1 If the care of a patient is transferred, each physician may claim for services provided on the day of transfer.

4.10.2 If a physician transfers the care of a hospitalized patient to a second physician, the second physician may claim daily care. The applicable benefit rate will be determined by the number of days of the patient's hospitalization except as provided in GR 4.10.3.

4.10.3 When the care of a patient is transferred to a second physician, the second physician may charge daily hospital care, starting at the rate allowed for the first to seventh day, only if the transfer was due to the onset of a significant new illness.

4.10.4 If a patient is transferred to another hospital under the care of another physician, hospital visit services shall be claimed as though this were a first admission.

4.10.5 A physician who admits a patient to hospital and provides pre-operative care but does not perform the surgery, may claim benefits for the services up to and including the day of surgery.

4.11 PSYCHOTHERAPY

4.11.1 A physician may submit claims for group psychotherapy, psychiatric management and/or indirect services for the same patient on the same day.

4.11.2 Psychotherapy or psychiatric management claims for time units may be submitted for separate encounters for the same patient on the same day.

4.11.3 Deleted

4.12 NEWBORN AND PREMATURE CARE - PEDIATRIC SPECIALIST

4.12.1 The benefit for care of a healthy newborn in hospital does not apply when the infant is ill. In these circumstances, the daily hospital visit HSCs apply.

4.12.2 If newborn and premature care is provided by a pediatrician,

a) HSC 03.05G may be claimed for care of a healthy newborn infant referred by anyone practicing obstetrics and in this instance no consultation benefit may be claimed;
b) if an infant appears initially well but becomes ill after a number of days and consultation is required as well as continuing daily care, benefits may be claimed for consultation under HSC 03.08A or 03.08AZ and the appropriate number of hospital days involved;
c) if consultation is requested during the newborn period and continuing care is not required, a consultation benefit may be claimed, but not HSC 03.05G and

d) subject to GR 4.12.1 routine care of a premature infant may be claimed as HSC 03.07A or 03.07AZ for the initial visit and continuing daily care benefits may be claimed as HSC 03.03D.

4.12.3 Routine care is considered to include minor conditions.

4.12.4 Routine follow-up visits provided for a premature infant after 90 days and 180 days of age may each be claimed under HSC 03.03A or 03.03AZ.

4.13 NEWBORN AND PREMATURE CARE - OTHER THAN PEDIATRICIANS

4.13.1 The benefit for care of a healthy newborn in hospital does not apply when the infant is ill. In these circumstances, the daily hospital visit HSCs apply.

4.13.2 If a physician performs the delivery and resuscitates the infant, HSC 13.99F may be claimed in addition to a delivery benefit.

4.13.3 The benefit for care of a healthy newborn in hospital may be claimed by the same physician who claimed the benefit for the delivery.

4.13.4 If newborn and premature care is provided by a physician other than a pediatrician,

a) the benefit for care of a healthy newborn may be claimed under HSC 03.05G whether or not the case is received as a referral;
b) if a consultation is required, a claim under HSC 03.05G may be claimed by the attending physician and a consultation benefit by the consultant;
c) if a newborn requires transfer to a consultant, a benefit to the attending physician may be claimed on a fee for service basis, and
d) subject to GR 4.13.5 routine care of a healthy premature newborn may be claimed as applicable visit HSCs.

4.13.5 Routine care is considered to include minor conditions.

4.13.6 Routine follow-up visits provided for a premature infant after 90 days and 180 days of age may each be claimed under HSC 03.03A, 03.03AZ or its equivalent.

4.14 POST PARTUM OFFICE VISITS

Whether the baby is ill or well the first office visit of a newborn, within 14 days of the date of birth, cannot exceed the "limited" evaluation rate if the physician has received payment for care of healthy newborn in hospital (HSC 03.05G) or inpatient care.
Subsequent to the initial post-partum visit, a physician may charge under whatever HSCs are appropriate for the care provided.

4.15 PRONOUNCEMENT OF DEATH

When a physician is specially called and attends on a priority basis to pronounce a death, a visit benefit may be claimed. There is no additional benefit for completion of a death certificate.

5 EMERGENCY/URGENT/CRITICAL CARE

5.1 EMERGENCY DEPARTMENT/AACC/UCC VISITS/ASSESSMENTS BY ROTATION DUTY PHYSICIANS OR BY PHYSICIANS PROVIDING FIRST CALL COVERAGE IN AN EMERGENCY DEPARTMENT THAT HAS GREATER THAN 25,000 VISITS TO THE EMERGENCY ROOM PER YEAR

5.1.1 HSCs 03.05CR, 03.05DR, 03.05ER, 03.05F, 03.05FA, 03.05FB may only be claimed by physicians on rotation duty or by physicians who are providing first call coverage in an emergency department that has greater than 25,000 visits to the emergency room per year. HSCs 03.05FR, 03.05GR, 03.05HR, 03.05FC, 03.05FD and 03.05FE may only be claimed by physicians on rotation duty in an AACC or UCC.

5.1.2 Only one of HSCs 03.05CR, 03.05DR, 03.05ER, 03.05FR, 03.05GR or 03.05HR may be claimed by either the same or a different physician, on the same date of service when the patient has remained in the emergency department, AACC or UCC.

5.1.3 Deleted

5.1.4 When the patient has been discharged from an emergency department, AACC or UCC and returns on the same day, another visit by the same or different physician may be claimed.

5.1.5 HSCs 13.99H and 13.99HA may not be claimed in association with another visit HSC. Time units may be claimed on a cumulative basis.

5.1.6 If a physician on rotation duty in a hospital emergency department or a physician who is providing first call coverage in an emergency department that has greater than 25,000 visits to the emergency room per year and a second physician submit claims for visits to the same patient on the same day, the following rules apply:

a) If the patient is not admitted, the physician on rotation duty or the physician who is providing first call coverage in an emergency department that has greater than 25,000 visits to the emergency room per year may be paid and the second physician may only be paid when specially called to attend that specific patient or in the case of follow-up care as described under HSCs 03.05F, 03.05FA, 03.05FB.

b) If the patient is admitted, both physicians may be paid and in this case, the second physician does not have to be specially called to claim for inpatient services.

5.1.7 If a physician working in an AACC or UCC, and a second physician submit claims for visits to the same patient on the same day, the physician working in an AACC or UCC may be paid and the second physician may only be paid when specially called from outside the facility to attend that specific patient.

5.2 SPECIAL CALLBACKS TO AACC/UCC/HOSPITAL EMERGENCY/OUT-PATIENT DEPARTMENT BY NON-ROTATION DUTY PHYSICIANS

5.2.1 HSCs 03.03KA, 03.03LA, 03.03MC and 03.03MD may be claimed when a physician is specially called from home or office to a hospital emergency department, AACC or UCC to attend one patient. Maximums apply, see GR 15.11.

5.2.2 If a physician is in a hospital, AACC or UCC for any purpose and is asked to see another patient in the hospital emergency room or the same AACC or UCC, HSCs 03.03KA, 03.03LA, 03.03MC, 03.03MD do not apply. Benefits may be claimed for the applicable visit or procedure.

5.2.3 Services provided to additional patients seen during the same callback, or services over the limits specified in GR 15.11 may be claimed as:
a) Deleted
b) HSC 03.02A, 03.03A, 03.03AZ, 03.03B, 03.03BZ, 03.04A, 03.04AZ as appropriate, or
c) the applicable procedure.

5.3 BENEFITS FOR INTENSIVE CARE SERVICES (ICU).

5.3.1 Services provided to patients on a ventilator are eligible for an additional benefit; refer to HSC 13.62A.

5.3.2 Benefits for unscheduled services may be claimed according to GR 15.

5.3.3 Deleted

5.3.4 Deleted

5.3.5 Deleted

5.3.6 Procedures performed in ICU are payable as follows:
a) the same encounter - the greater procedure at 100% and other procedures at 75% unless otherwise specified in the Schedule.
b) to obtain payment at 100% for two or more procedures on the same date of service, the claim must indicate that the service was performed at a separate encounter.

5.4 Deleted

5.4.1 Deleted

5.4.2 Deleted

5.4.3 Deleted

5.4.4 Deleted

5.5 Deleted

5.5.1 Deleted

5.5.2 Deleted

5.5.3 Deleted
a) Deleted
b) Deleted
c) Deleted

5.5.4 Deleted

5.5.5 Deleted

5.6 Deleted

5.6.1 Deleted

5.6.2 Deleted
a) Deleted
b) Deleted

5.6.3 Deleted
a) Deleted
b) Deleted
c) Deleted
d) Deleted
e) Deleted
f) Deleted

5.6.4 Deleted

5.6.5 Deleted

5.6.6 Deleted

5.6.7 Deleted

6 PROCEDURES

6.1 If a physician performs a minor procedure and provides a service warranting a claim for an office visit or a home visit on the same day, benefits for both may be claimed only if the services and diagnoses are unrelated.

6.2 If a service is provided in a hospital emergency department, AACC or UCC, only the minor procedure or the visit benefit, whichever is the greater, may be claimed, unless the problems are emergencies and the diagnoses are unrelated.

6.3 A procedure benefit includes removal of sutures. The physician who placed sutures may not claim for removing them. A second physician who is in the same practice group as the surgeon may not claim for removing the sutures either. However, a second physician may claim a visit for removal of sutures if he is not a member of the same practice group as the practitioner who put the sutures in.

6.4 Anesthetic benefits for local infiltration are included in the benefit for the procedure.

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

03.12A 03.16A 03.16B 03.19C 03.19D 03.37A

03.37B	03.38A	03.38B	03.38C	03.38D	03.38E
03.38F	03.38G	03.38H	03.38K	03.38M	03.38N
03.38P	03.38Q	03.38R	03.38S	03.38T	03.38X
03.39A	03.39B	03.41A	03.41B	03.41C	03.41D
03.44A	03.52A	03.52B	03.52C	03.52D	03.55A
03.55B	03.56A	03.56B	07.09A	07.09B	09.01A
09.01B	09.01C	09.01E	09.02B	09.05A	09.05B
09.06A	09.07C	09.11A	09.11B	09.11C	09.12A
09.12B	09.13C	09.13D	09.13E	09.13F	09.13G
09.13H	09.21B	09.23A	09.23B	09.24B	09.26A
09.26D	09.41A	09.41B	09.43A	09.43B	09.43C
09.43D	09.43E	09.46A	09.49A		
13.99CC	24.89A	32.81	49.98T	50.98A	
95.94C	98.8 A	98.89A	98.89B	98.89C	98.89D
98.89E	98.89F	98.89H	98.92E	98.99F	
F7					

6.6 DIAGNOSTIC SURGICAL PROCEDURES

6.6.1 If a patient is admitted to a hospital for the purpose of undergoing a procedure designated "+", a benefit is payable for a visit provided the day before or the day after the procedure is performed, but if the procedure is performed and a visit occurs on the same day, a benefit is payable for either the procedure or the visit, but not both.

6.6.2 If a procedure designated "+" is performed in a physician's office, both the procedural benefit and the appropriate office visit benefit for that day may be claimed, but if a consultation benefit pursuant to GR 6.6.4 has been claimed, a visit benefit will not be payable for the day on which the procedure is performed.

6.6.3 If a procedure designated "+" is performed in a place other than a physician's office, either a procedural benefit or a visit benefit, but not both, may be claimed for that day.

6.6.4 If a procedure designated "+" and a consultation are provided on the same day, both the procedural benefit and the appropriate consultation benefit are payable.

6.7 MINOR PROCEDURES

6.7.1 If a minor procedure (M or M+) is provided with a hospital visit on the same day, only the greater benefit HSC may be claimed.

6.7.2 When more than one procedure with a "V" category is provided at the same encounter only the greater benefit may be claimed.

6.7.3 Deleted

6.8 MAJOR PROCEDURES

6.8.1 HSCs with a designated category code of 1 and 15 include related post-operative services and those with a designated category code of 3, 4, 6 and 14 include both related pre-operative and post-operative services.

a) a consultation benefit may be claimed up to and including the day of surgery.

b) pre-operative hospital care may be claimed by the physician who performs the surgery if information is submitted to show that conservative treatment was attempted before surgery was performed.

c) benefits may be claimed as applicable for complications occurring during or following post-operative time periods.

d) Deleted

e) HSC 03.04R may be claimed in the pre-operative time frame when all conditions in the notes have been met.

The following chart gives the pre-operative and post-operative periods.

Category	Pre-operative	Post-operative
1	0 - Days	14 - Days
3	7 - Days	7 - Days
4	7 - Days	14 - Days
6	14 - Days	14 - Days
14	30 - Days	14 - Days
15	0 - Days	7 - Days

6.8.2 Deleted

6.8.3 Deleted

a) Deleted

b) Deleted

6.8.4 Where a procedure is performed under general anesthesia, the following applies:

a) If the procedure is the only procedure performed at that time, a benefit of $134.85 may be claimed.

b) If another procedure is also performed at the same encounter and the listed benefit payable in respect of it under the Schedule is greater than $134.85 the physician is entitled to receive that listed benefit plus a percentage of the listed benefit for the lesser procedure(s) calculated in accordance with this Schedule. The $134.85 minimum benefit does not apply to the lesser procedures.

c) If multiple procedures are performed at the same encounter and the listed benefit payable in respect of each of them under the Schedule is less than $134.85, the physician is entitled to receive a benefit of $134.85 in respect of the greater procedure plus a benefit in respect of each of the lesser procedures that is a percentage of the listed benefit and calculated in accordance with this schedule. The $134.85 minimum benefit does not apply to the lesser procedures.

d) If multiple procedures are performed at the same encounter and only one of them appears under GR 6.8.4 (e), the physician is entitled to receive a benefit of $134.85 in respect of that procedure plus a benefit in respect of the other procedures that is a percentage of the listed benefit and calculated in accordance with this schedule.

e) GR 6.8.4 applies to the following HSCs:

01.01A	01.01B	01.03	01.09	01.24A	01.24B
01.24BA	01.24BB	02.84B	03.22A	03.22B	03.25
07.29A	07.57A				
10.23	10.25	11.71A	11.81A	12.01	12.21
12.24	12.31	13.59L	13.59N	13.59O	13.99BB
14.09A	17.39E	17.81A	19.81		
21.41	21.42	21.69A	21.69C	22.13B	22.13C
22.5 A	22.81	24.22A	24.5	25.1 A	26.91A
28.8 A					
30.19A	30.19B	30.9 A	32.01A	32.1	32.21A
32.23A	32.39A	33.22A	33.22B	33.51A	33.51B
33.61A	34.0 A	34.1 A	34.89A	35.0 A	37.81
37.82A	38.0 A	38.89A	39.21A	39.62A	39.83A
40.5	40.92A	43.95A	45.81A	45.83	45.84A
46.04B	46.09B	46.09C	46.84A	49.0	49.82B
49.83A					
50.4 A	50.94D	50.94E	50.94F	50.97A	51.43
51.53A	52.1 A	53.81B	53.83A	54.92D	58.99F
60.82C	61.01A	61.29B	61.37A	61.39B	62.81A
64.95A	66.82A	67.81	67.86	67.96A	68.1
68.32B	69.13D	69.29A	69.83A	69.83B	
70.1	70.2 A	70.2 B	70.2 H	70.4 F	
70.5 A	72.91	74.82A	76.91A	78.7 A	79.29E
80.83B	80.85B	81.8	81.96	82.12A	82.12B
82.12C	82.14D	82.81A	82.91A	83.7 A	87.6
87.72A	87.82	87.89A	87.89B	87.91	87.92
88.92	89.59A				
91.01H	91.01J	91.02A	91.03A	91.03B	91.05E
91.05H	91.06D	91.06E	91.07A	91.08B	91.70A
91.70B	91.71	91.73A	91.73B	91.77B	91.77C
91.78A	91.78B	92.70	92.71	92.72	92.74
92.75	92.76	92.78C	93.91A	93.91B	94.04
95.02A	95.03	95.81A	95.93	95.96A	
97.81	97.96	98.03A	98.04A	98.12A	98.12B
98.12C	98.12E	98.12G	98.12H	98.12J	98.12K
98.12M	98.12N	98.12Q	98.12R	98.22A	98.49A
98.6 A	98.6 C	98.81A	98.93A	98.93B	98.96A
98.96B	98.96C	98.96D	98.98B		

6.8.5 GR 6.8.4 does not apply to surgical assistance or anesthetic benefits.

6.8.6 If a surgeon does not provide the major portion of the post-operative care, the surgical benefit may be reduced to a lesser rate than listed for the procedure.

6.8.7 The physician providing the post-operative care under GR 6.8.6 may submit claims on a fee for service basis.

6.8.8 For those unusual situations where surgery is performed by a travelling surgeon (in accordance with the policy of the CPSA) the full benefit for the procedure may be claimed. If another physician participates in post-operative care his/her services may be claimed on a fee for service basis.

6.9 MULTIPLE PROCEDURES

6.9.1 If 2 similar procedures are performed at one time, the 2nd procedure may be claimed at 75% of the listed benefit unless otherwise indicated in the schedule.

6.9.2 If 2 different procedures are performed by one surgeon through separate incisions under one anesthetic, the claim for the lesser procedure may be claimed at 75% of the listed benefit.

6.9.3 If 2 unrelated procedures are performed through the same incision, the benefit for the lesser procedure may be claimed at the rate of 75% of the listed benefit.

6.9.4 If 2 unrelated procedures are performed by 2 physicians in different anatomical areas utilizing the same anesthetic, the benefit for each procedure may be claimed according to the listed benefit.

6.9.5 If multiple related procedures are performed through one incision, by one physician, a benefit may be claimed for the major procedure only.

6.9.6 If multiple unrelated abdominal procedures are performed through one incision, by more than one physician, the benefit for the major procedure may be claimed in full by the physician most responsible for the patient's care and at 75% by the other physician, irrespective of the value of either procedure.

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

a) a fracture that is otherwise provided for in this Schedule,
b) a dislocation,
c) a procedure considered to be part of an inclusive benefit, or
d) a secondary procedure that is paid in full as an additional item or as an interpretation of a diagnostic test as a listed benefit in the Schedule,
e) a procedure listed in the following table which may be claimed at 100% when performed as a second or subsequent procedure by any physician, regardless of whether the procedures are performed by one or more physicians and regardless of whether additional incisions are required to perform the procedure. This does not apply to anesthetic services; refer to GR 12.4.9.

16.09N	16.09O	16.09P	16.3 A	16.3 B	16.43D
16.43E	16.49B	16.49C	16.49D	16.49E	16.49F
16.49G	17.08A	17.39C	17.5 D		
52.12	52.13	52.42	65.04C	65.1 A	

89.09A	89.12A	89.12B	89.19A	89.20A	89.21
89.22A	89.22B	89.24	89.26A	89.36A	89.36C
89.37A	89.37B	89.38B	89.38C	89.38D	89.38E
89.38F	89.38G	89.41A	89.41B	89.42A	89.59F
89.59G	89.6 A	89.78D	89.78H	89.78I	89.78J
89.78K	89.78L	89.78M	89.78N	89.78P	89.78Q
89.78R	89.78S	89.78T	89.78U	89.78V	89.78W
89.78X	89.78Y	89.85	89.88A		
90.00A	90.01	90.02B	90.02C	90.03A	90.03C
90.04	90.05A	90.06A	90.06B	90.07A	90.07B
90.09A	90.09B	90.09C	90.2 A	90.32A	90.32B
90.34A	90.34B	90.39A	90.5 A	90.5 B	90.6 D
90.6 E	90.6 F	91.00B	91.00E	91.01E	91.01G
91.04E	91.05K	91.06C	91.08G	91.08L	91.09A
91.09B	91.10A	91.14A	91.14B	91.14C	91.15A
91.15B	91.22A	91.22B	91.30A	91.30B	91.30C
91.30D	91.30F	91.30G	91.30H	91.30I	91.31B
91.31C	91.31D	91.31E	91.31F	91.31G	91.31H
91.31J	91.31K	91.32D	91.33B	91.34A	91.34B
91.34C					
91.34D	91.34E	91.34F	91.34G	91.34H	91.35A
91.35B	91.35C	91.35D	91.35G	91.35H	91.35K
91.35L	91.35M	91.35N	91.36A	91.36B	91.36C
91.36D	91.36E	91.36G	91.36H	91.36I	91.37A
91.38A	91.38D	91.38F	91.38H	91.38J	91.38K
91.44B	91.74B	91.80			
91.80A	91.81	91.82A	91.84A	91.84C	91.84D
91.85A	91.86	91.87A	91.87B	91.88A	91.88B
91.88C	91.90A	92.10	92.11	92.14	92.31C
92.31D	92.31E	92.31F	92.31H	92.31J	92.31K
92.31L	92.31M	92.31N	92.31P	92.31Q	92.31R
92.31S					
92.32B	92.32C	92.32D	92.40	92.41	92.44
92.45	92.46	92.8 A	92.8 B	92.8 C	92.8 D
93.01A	93.01B	93.02A	93.02B	93.05D	93.05E
93.06A	93.09B	93.09C	93.09D	93.09E	93.09F
93.09G	93.09H	93.11A	93.12A	93.12B	93.12C
93.13A	93.14	93.16A	93.18A	93.18B	93.21
93.22	93.23	93.24	93.25	93.26A	93.39B
93.39C	93.41A	93.44A	93.45A	93.45B	93.45C
93.45D	93.45E	93.45F	93.45G	93.45H	93.45J
93.45K	93.47A	93.47C	93.49A	93.49B	
93.49C	93.59A	93.6 A	93.6 B	93.69A	93.69B
93.69C	93.71A	93.71D	93.8 A	93.81A	93.81B
93.83B	93.83C	93.83D	93.83E	93.83F	93.83G
93.83H	93.83I	93.83N	93.83O	93.84A	93.85A
93.87A	93.87E	93.87J	93.87K	93.96B	93.96C
93.96D					
93.96E	93.96F	93.96G	93.96H	93.96I	93.96J

93.96K	93.96L	94.01B	94.35A		
95.01B	95.12	95.13A	95.13B	95.14E	95.15A
95.15B	95.15C	95.15F	95.15G	95.19A	95.29A
95.32B	95.4 A	95.4 B	95.54A	95.54B	95.54D
95.54E	95.54F	95.54G	95.65B	95.65C	95.65D
95.65E	95.65F	95.66B	95.71B	95.75A	95.75B
95.76A	95.76B	95.76C	95.77A	95.78A	95.78B
95.78C	95.91C	95.99A	96.05	96.06	96.07
96.08	96.11A	96.13	96.14	96.15	96.16
96.17	97.11B	97.22A	97.29A		

f) a procedure listed in the following table that may be claimed at 100% when performed as a second or subsequent procedure through a different incision by any physician, regardless of whether the procedures are performed by one or more physicians. This does not apply to anesthetic services; refer to GR 12.4.

66.3 B	71.7 A	71.7 B	78.52C	78.99B	79.1 A
79.3 E	80.19A	80.19B	80.19C	80.19D	80.19E
80.81	80.83B	81.09	81.29B	81.29C	81.51A
81.99A	81.99C	82.12A	82.12B	82.12C	82.12D
82.3 A	82.3 B	82.41A	82.42A	82.51A	82.62A
82.63	82.64B	82.69B	82.69D	82.69E	82.7 A
82.81A	82.91A	83.19A	83.4 A	83.4 B	83.5 A
83.61	83.69B	83.7 A	83.9 A		

g) Procedures in different groups in the following table may be claimed at 100% each when performed at the same operative encounter. For example, procedures listed in group B may be claimed at 100% when performed at the same operative encounter as procedures listed in group A. Two procedures from the same group will continue to be paid at 100% and 75% for second and subsequent procedures. This does not apply to anesthetic services; refer to GR 12.4.

Group A

19.3 A	19.7 A	19.7 B	20.12	38.22B	41.42
43.1 B	43.63A	52.11A	54.09A	54.12	

Group B

45.1 A	46.64A	46.64B	46.81A	50.77A	54.79B

Group C

52.89A	53.34	53.53A	54.76A	54.79A	55.2 A
55.3	56.2	56.39A	56.4 A	56.93A	56.93F
57.0 A	57.04A	57.12A	57.12B	57.14A	57.42A
57.42B	57.59A	57.6 A	57.6 B	57.6 D	57.6 E
57.7	57.82A	57.92A	58.11A	58.39A	58.42A
58.44A	58.73	58.75A	58.81A	58.81B	58.81C
59.0 A	60.24C	60.39A	60.4 A	60.52A	60.52B
60.65	62.12A	62.12C	62.2 B	62.51	63.12A
63.12B	63.12D	63.14	63.27	63.41	63.69A
63.89A	64.09A	64.3	64.43A	64.49A	64.7
65.7 A	65.7 B	65.9 E	66.19B	66.51A	66.52
66.63	66.89A	67.01A	67.4 D	67.71	69.73B

Group D

60.54	60.59A	60.59B	60.66A	60.71B	60.82C

61.01B	61.03	61.2 A	61.29B	61.36A	61.39B
61.4 A	61.63A	61.69B	66.3 C	72.52	

6.9.8 Unless otherwise stated in the schedule, if a surgical procedure and related diagnostic procedure are performed by the same physician, utilizing the same anesthetic, only the greater benefit may be claimed.

6.9.9 Claims may not be submitted for incidental procedures.

6.10 BILATERAL SURGERY - TWO SURGEONS

With the exception of the HSCs listed under GR 6.9.7e, when two surgeons operate on two sides at the same time, the surgeon most responsible for the patient's care may claim 100% of the listed benefit for the procedure she/he performs and the second surgeon may claim 75% of the benefit for the procedure she/he performs.

6.11 FRACTURES AND DISLOCATIONS

6.11.1 For a compound fracture, closed or open reduction, 150% of the listed benefit may be claimed.

6.11.2 For an uncomplicated fracture without displacement, only 50% of the listed benefit may be claimed.

6.11.3 With the exception of facial fractures treated by closed reduction, multiple fractures, other than undisplaced fractures, may be claimed at the full benefit for each fracture treated by closed reduction, open reduction, continuous traction or extensive skeletal traction. This does not apply to anesthetic services; refer to GR 12.4.9.

6.11.4 Deleted

6.11.5 If an open operation is performed for the purpose of implanting an electrical stimulator, for conditions such as non-union of fractures, the appropriate HSC for open reduction of the fracture may be claimed.

6.11.6 With the exception of 90.09A, 90.09B and 90.09C, benefits for bone grafting or bone graft harvesting and fixation (90.00 through 90.08 series) may not be claimed in association with an open reduction of a fracture of the same bone.

6.11.7 Benefits for bone grafts include harvesting and fixation where indicated.

6.11.8 Osteotomy (all HSCs 89.2 and 89.3 series) may not be claimed in association with the following:

a) bone grafting (all HSCs 90.00 to 90.08 series) when performed at the same encounter
b) primary or revision arthroplasty when the osteotomy is of an adjacent bone.

In these cases, only the greater benefit may be paid.

6.11.9 For open reduction and mini plate fixation of facial fractures, if a bone graft is required to fill a defect, 75% of HSC 98.79A may be claimed in addition to the benefit for the fracture.

6.11.10 For an open reduction of a periprosthetic fracture (a fracture involving bone around any prosthesis), of a long bone when no revision arthroplasty of the same long bone is performed, 150% of the benefit for open reduction and internal fixation of the bone involved may be claimed using modifier PROSTH.

6.11.11 Benefits for orthopedic services include the application of a cast when required and replacement of the cast within the 14 day post operative period.

6.12 FRACTURES AND DISLOCATIONS - ATTEMPTED REDUCTION

6.12.1 If a physician attempts a closed reduction of a fracture unsuccessfully and finds it necessary to transfer the care of the patient to another physician, the referring physician may claim 100% of the benefit listed for such fractures.

6.12.2 The listed benefit may be claimed by the physician receiving the transferred patient and providing the final reduction.

6.13 FRACTURES AND DISLOCATIONS - OPEN FOLLOWING CLOSED REDUCTION

6.13.1 If the same physician performs an open reduction following an attempted closed reduction, under the same anesthetic, only the benefit for open reduction may be claimed.

6.13.2 If the same physician performs an open reduction following an attempted closed reduction, under a different anesthetic, benefits for both may be claimed.

6.13.3 An additional 50% of the listed benefit may be claimed by orthopedic surgeons for open reduction of a fracture with demonstrated radiographic non-union at least 12 weeks from the date of the initial fracture (NUFRAC modifier).

6.14 SAME PHYSICIAN, SEVERAL FUNCTIONS

6.14.1 In relation to either a single surgical procedure or a series of procedures under the same anesthetic, only the surgical or the anesthetic benefit, whichever is the greater, may be claimed.

6.14.2 Notwithstanding GR 6.14.1, the same physician who claims HSC 87.98B may also claim a surgical assist for cesarean section on the same patient on the same day. The conditions indicated under HSC 87.98B must also be met.

6.14.3 Notwithstanding GR 6.14.1, in a rural location, a physician may claim both HSC 87.98B and an anesthetic service on the same day when:

a) he or she must call in another physician to complete the delivery and
b) he or she provides an anesthetic service for the delivery and
c) the conditions indicated under HSC 87.98B have been met.

6.14.4 A physician acting as both a surgical assistant and a surgeon for separate procedures under one anesthetic may submit a claim for both services.

6.14.5 When complex orthopedic surgery requires the skills of two orthopedic surgeons, the second surgeon may submit a claim using modifier SSOS for his/her services when he/she has actively participated in the planning for and performance of the procedure. Only the second orthopedic surgeon's surgical time may be claimed; time spent in planning the procedure may not be included in the claimed time. Claims shall indicate the total number of time units spent and may not exceed the anesthetic time claimed for the procedure.

Claims for HSCs that do not list modifier SSOS in the Price List may be submitted with supporting information.

6.15 REDO CARDIAC, VASCULAR AND THORACIC SURGERY

6.15.1 With the exception of the HSCs specified under GR 6.15.4, benefits that may be claimed for redo cardiac, vascular and thoracic surgery are as follows:

a) 150% of the listed benefit if the procedure is performed entirely through a previous incision;
b) 125% if part of the procedure is performed through a previous incision.

6.15.2 HSCs 46.03B, 47.92C, 50.75A and 51.98A are defined as having a reoperative component and therefore are not eligible for redo modifiers. HSCs 51.61A and 51.61B are also not eligible for redo modifiers.

6.15.3 A claim for a redo modifier may not be submitted unless the patient has left the operating room and post anesthetic recovery room.

6.15.4 Benefits that may be claimed for redos for one of the following HSCs vary depending on how many redos have been performed in the past, (whether partly or wholly), through that incision. The first redo may be claimed at 175% of the listed benefit, the second at 225%, the third at 275%, the fourth at 325%, and the fifth at 375%.

44.21	44.3 A	44.3 B	44.4 A	44.4 B	44.4 C
44.5 A	44.5 B	45.1 A	45.1 B	45.5 A	46.3 C
47.02A	47.02C	47.04	47.12A	47.12B	47.13A
47.13B	47.13C	47.14A	47.14B	47.15A	47.15B
47.15C	47.23A	47.23B	47.25A	47.25B	47.25C
47.25D	47.27A	47.29A	47.39A	47.54A	47.54B
47.55A	47.55B	47.55C	47.81	47.82	47.83A
47.83B	47.84A	47.91A	47.92A	47.92B	47.93A
47.93B	47.95A	48.12	48.12A	48.13	48.13A
48.14	48.14A	48.15A	48.15B	48.15C	48.15D
48.15E	48.15F	48.15G	48.15H	49.12	49.12B
49.2 A	49.2 B	49.31	49.39	49.39B	49.39C
49.4 B	49.5 A	49.61A	49.62A	49.62B	49.64A
49.7 C	49.7 J	49.7JA	49.7 K	49.7KA	49.7 L
49.7LA	49.7 M	49.7MA	49.9 A	49.91	49.98X
50.04A	50.05A	50.14	50.15A	50.24A	50.24B
50.34A	50.34B	50.34D	50.34K	50.34L	50.75B
50.75C	51.21A	51.21B	51.21C	51.3 C	

6.15.5 In cases where multiple redos are performed at the same encounter through the previous incision, the lesser procedures will be paid at 75% of the redo modifier benefits.

6.16 An additional 50% of the listed benefit may be claimed for cardiovascular and thoracic surgery when performed on neonates (as defined under GR 1.16) and infants under 44 weeks of conceptual age (as defined under GR 1.15).

6.17 REDO ORTHOPEDIC SURGERY

6.17.1 An additional 50% of the listed benefit may be claimed using modifier ORREDO by orthopedic surgeons for redo orthopedic surgery on or relating to the same joint or muscle structure on which the patient has previously had an orthopedic surgical intervention. The ORREDO modifier is listed in the Price List for eligible HSCs.

6.18 GENERAL SURGERY

6.18.1 An additional 25% of the benefit may be claimed for general surgery procedures when performed on patients 90 days of "corrected age" as defined by GR 1.25 or younger.

6.18.2 An additional benefit of 50% may be claimed for procedures performed on infants of less than 40 weeks conceptual age as defined under GR 1.15.

7 RECONSTRUCTIVE PLASTIC SURGERY

7.1 DEFINITIONS

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).
NOTE: Paired structures would be claimed as two separate areas, e.g., right and left wrist would be claimed as two separate areas.

7.1.2 NON - FUNCTIONAL AREA

Non-functional area includes the following anatomical areas: Posterior trunk, anterior trunk, arm (above elbow), forearm (below elbow), thigh, leg (below knee).
NOTE: Paired structures would be claimed as two separate areas, e.g., right and left arm would be claimed as two separate areas.

7.1.3 TYPES OF INJURY

a) Acute: Primary - refers to procedure within 10 days,
b) Subacute: Secondary - refers to procedure within 11-21 days,
c) Chronic: refers to procedures more than 21 days after injury.

7.2 GRAFTS

7.2.1 When multiple grafts are applied within the same anatomical area, the total number of square centimetres per anatomical area should be claimed.

7.2.2 When grafts are applied to multiple anatomical areas, whether non-functional or functional, payment will be as follows:

a) first anatomical area - 100% of listed benefit.

b) second and subsequent anatomical area(s) - 75% of the listed benefit.

7.3 FLAPS AND TISSUE RESECTION

7.3.1 Multiple flaps (non z-plasty flaps) are claimed at 100% of the listed benefit for the first and 75% of the listed benefit for each subsequent flap. A donor defect resulting from a major flap, which requires a skin graft or pedicle flap greater than 5 cms is claimed at 75% of the listed benefit.

7.3.2 Benefits for tissue resection required prior to reconstruction may be claimed in addition to the benefits for reconstruction. The greater benefit may be claimed at 100% and the lesser at 75%. Only one tissue resection benefit may be claimed per anatomical area.

8 OBSTETRICS AND GYNECOLOGY

8.1 OBSTETRICS - GENERAL

8.1.1 Obstetrical care is divided into its components. An initial prenatal visit 03.04B includes a full history, examination, completion of the prenatal record and advice to the patient. Usual prenatal care includes a prenatal visit, follow-up visits which would generally occur at four-week intervals to 32 weeks, followed by visits every second week to 36 weeks, then weekly visits until delivery. Additional visit or procedure items may be claimed as required for complicated pregnancies.

8.1.2 Prenatal visits (HSC 03.03B), emergency, outpatient and inpatient hospital visits may be claimed up to the time of delivery, including the day of delivery; except in the situation where delivery occurs within 24 hours of admission, in which case neither a hospital admission (03.04C) nor a hospital visit (03.03D) may be claimed.

8.1.3 Deleted

8.1.4 The delivery benefit includes payment to the attending physician for procedures such as surgical induction, episiotomy, repair of episiotomy or non-extensive lacerations (first or second degree as defined below), and ordinary immediate care of the newborn.

First degree is defined as a superficial laceration of the vaginal mucosa or perineal body which does not require suturing.

Second degree is defined as a laceration involving the vaginal mucosa and/or perineal skin and deeper subcutaneous tissue and requiring suturing.

Third degree is defined as an extension of the laceration which involves any part of the capsule or anal sphincter muscle or deep vaginal sidewall laceration.

Fourth degree is defined as extensive including involvement of the rectal mucosa.

8.1.5 When a delivery occurs within 24 hours of admission, the delivery benefit includes the hospital admission (HSC 03.04C) or hospital visit (03.03D). Post-partum hospital visits, by the same or different physician, for the period of one week after the delivery, and ordinary immediate care of the newborn are also included.
When there is a life threatening situation which requires neonatal resuscitation, HSC 13.99F may be claimed as well.

8.2 Deleted

8.2.1 Deleted

8.2.2 Deleted
a) Deleted
b) Deleted
c) Deleted
d) Deleted

8.3 GYNECOLOGY

8.3.1 Deleted

8.3.2 If a gynecological procedure results in sterilization, 78.99B may not be claimed in addition.

9 OPHTHALMOLOGY

9.1 CLAIMS FOR COMPLETE EYE EXAMINATIONS AND SPECIAL EXAMINATIONS

9.1.1 The following examinations are included in the complete examination (03.04A, 03.04AZ, 03.08A, 03.08AZ, 03.08H, 09.04) and may not be claimed in addition:
Measurement of vision
Refractive error
Extra-ocular muscle balance
03.12A Intra-ocular pressure measurement
09.01A Biomicroscopy (slit lamp examination)
Retinal examination

9.1.2 Three technical services and three interpretive services from the following examinations may be claimed in addition to HSCs 03.04A, 03.04AZ, 03.08A, 03.08AZ, 03.08H and 09.04:
09.01B Gonioscopy
09.01C Orthoptic analysis, interpretation
09.01E Orthoptic analysis, technical (may include Hess screen)
09.02B Anterior chamber depth measurement
09.02E Amblyopia evaluation for patients nine years of age or younger
09.05A Full threshold perimetric examination, technical
09.05B Full threshold perimetric examination, interpretation
09.06A Color vision test, interpretation and technical
09.11A Bilateral specular microscopy for corneal graft patients only - technical
09.11B Bilateral specular microscopy for corneal graft patients only - interpretation
09.11C Potential acuity measurement (PAM)
09.12A Intravenous fluorescein angiography (IVFA), interpretation
09.12B Intravenous fluorescein angiography (IVFA), technical

09.13E Optical coherence tomography (OCT), interpretation
09.13F Optical coherence tomography (OCT), technical
09.26A Diurnal tension curve
09.26D Bilateral corneal pachymetry
21.31A Diagnostic irrigation of nasolacrimal duct, office procedure, per eye
24.89B Diagnostic conjunctival scraping
25.81A Diagnostic corneal scraping

9.1.3 Three technical services and three interpretive services from the following examinations may be claimed in addition to HSCs 03.02A, 03.03A, 03.03AZ, 03.07A, 03.07AZ, and 03.07B:
03.12A Intraocular pressure measurement
09.01A Biomicroscopy (slit lamp examination)
09.01B Gonioscopy
09.01C Orthoptic analysis, interpretation
09.01E Orthoptic analysis, technical (may include Hess screen)
09.02B Anterior chamber depth measurement
09.02E Amblyopia evaluation for patients nine years of age or younger
09.05A Full threshold perimetric examination, technical
09.05B Full threshold perimetric examination, interpretation
09.06A Color vision test, interpretation and technical
09.11A Bilateral specular microscopy for corneal graft patients only - technical
09.11B Bilateral specular microscopy for corneal graft patients only - interpretation
09.11C Potential acuity measurement (PAM)
09.12A Intravenous fluorescein angiography (IVFA), interpretation
09.12B Intravenous fluorescein angiography (IVFA), technical
09.13E Optical coherence tomography (OCT), interpretation
09.13F Optical coherence tomography (OCT), technical
09.26A Diurnal tension curve
09.26D Bilateral corneal pachymetry
21.31A Diagnostic irrigation of nasolacrimal duct, office procedure, per eye
24.89B Diagnostic conjunctival scraping
25.81A Diagnostic corneal scraping

9.1.4 When done independently on a separate day or as a repeat, not more than three interpretations and three technical services from the list in GR 9.1.3 may be claimed.

9.1.5 Deleted

9.1.6 Unless otherwise specified, the HSCs listed under GR 9.1.2 and 9.1.3 include both the technical and interpretive components.

9.2 Deleted

9.2.1 Deleted

9.2.2 Deleted

10 DENTAL/ORAL SURGICAL RELATED SERVICES

10.1 The appropriate listed anesthetic benefit or the number of time units for the procedure may be claimed when the oral surgical procedure is listed under the Schedule of Oral and Maxillofacial Surgery Benefits.

10.2 Anesthesia for dental service HSC 36.99AA is insured only when one of the following criteria is met:

10.2.1 The patient has a severe mental or physical disability that precludes the performance of the dental procedure under local anesthetic or;

10.2.2 The presence of dental disease adds a significant risk of complications to a planned open cardiac or organ transplant procedure or for patients with a compromised immune system or;

10.2.3 A child 17 years of age and under requires extensive dental rehabilitation and could not otherwise be treated due to the length of time for the treatment.

10.3 Claims for anesthetic services for intravenous sedation and physiologic monitoring may be claimed as HSC 36.99AA for patients in hospital, when such service is medically required.

10.4 Subject to 10.1, 10.2 and 10.3, if a patient has been admitted to hospital for dental extraction or another dental treatment procedure or an oral surgical procedure and the admitting physician does not administer a general anesthetic:

10.4.1 Pre-operative services shall be claimed under the appropriate hospital or office visit HSCs (generally HSCs 03.03A, 03.03AZ, 03.04A, 03.04AZ, 03.04C, 03.04M) and;

10.4.2 Post-operative services shall be claimed under the appropriate hospital visit HSC 03.03D.

10.5 Subject to 10.1, 10.2 and 10.3, if a patient has been admitted to hospital for dental extraction or another dental treatment procedure or an oral surgical procedure and the admitting physician administers a general anesthetic, the physician may claim hospital daily care for the days preceding and following surgery but not for the day of surgery. For the day of surgery, only the greater benefit of the anesthetic service or the visit may be claimed.

10.6 Where applicable, physicians' services provided at the request of a dentist may be claimed as consultations, providing the provisions of GR 4 relating to consultations are met. With the exception of the services listed under GR 10.2, if the request relates to an uninsured dental service, neither a consultation or visit may be claimed.

11 LABORATORY/PATHOLOGY/RADIOLOGY

11.1.1 Claims for services under the pathology and radiology sections will not be payable unless the physician has been approved by the CPSA to provide those services.

11.1.2 The benefit rates listed in the Schedule which pertain to laboratory and pathology services including HSC 50.99A, may only be claimed for services provided to out of province Canadian residents.

11.2 ELECTROCARDIOGRAPHY/TAPE ECG/CARDIOVASCULAR STRESS TESTING

A claim for HSCs 03.41A, 03.41B, 03.41C, 03.44A, 03.52B, 03.52D, 03.55B and 03.56B may be submitted by physicians who have been approved by the CPSA to provide these services. For purposes of claims for HSC 03.52D, CPSA approval for ECGs will be used as a proxy.

11.2.1 PULMONARY FUNCTION PROCEDURES

Physicians performing procedures identified as Level I do not require approval from the CPSA to perform these services. These services are reflected in HSCs 03.37A, 03.37B, 03.38D, 03.38E and 03.38R. Physicians performing procedures identified by the CPSA as requiring either Level II, III or IV require approval and may only be claimed by physicians with the appropriate level of CPSA approval.

In addition to Level I procedures, physicians with Level II approval may claim:

03.38A 03.38B 03.38C 03.38F 03.38G

In addition to Level I and Level II procedures, physicians with Level III approval may claim:

03.38H 03.38K 03.38M 03.38N 03.38P 03.38Q 03.38S
03.38T 03.38X

11.2.2 The CPSA accredits facilities for the performance of Pulmonary Function Tests (PFT). With the exception of interpretive services, physicians may only perform Level II or higher PFT services in accredited facilities, and must ensure that claims submitted for these services include the applicable facility number. Claims for services provided in non-accredited facilities or hospitals as per GR 6.5 will not be paid.

11.2.3 EVOKED POTENTIAL

A claim for HSCs 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.

11.3 DIAGNOSTIC IMAGING

11.3.1 The benefit for any one region is intended to cover a sufficient number of films to establish a diagnosis in the ordinary case.

11.3.2 Films taken prior to and subsequent to the reduction of a fracture may be claimed in full.

11.3.3 Benefits are intended for diagnostic or therapeutic purposes. Mass screening services with the exception of HSCs X27C, X27D, X27E and X27F are not to be claimed.

11.3.4 OPAQUE MEDIA

Except as otherwise indicated in this schedule, the radiologic benefit listed includes the cost of opaque material used.

11.3.5 EXTREMITIES

Limited bilateral examination for conditions such as arthritis, gout, epiphysial development, etc., may be claimed as one such region and the unilateral fee shall apply.

Contralateral views of an opposite extremity when ordered by a radiologist, routinely or in an occasional case, shall be considered as part of the examination and the unilateral fee shall apply.

11.3.6 COMPARATIVE VIEWS

If the referring physician requests imaging of a contralateral joint or extremity for comparative views, then an additional 50% may be claimed for the second side.

11.3.7 An entire extremity in infants and young children for such injuries as a wringer injury may be claimed only as the greater benefit for a single area of such extremity.

11.3.8 Soft tissue examinations may be claimed as for a single area of the adjacent bone or joint.

11.3.9 A foot and ankle examination may constitute two separate benefits.

11.3.10 HEAD

Bilateral areas of the skull, such as mastoids, optic foramina, orbits and internal auditory meati shall include complete views of both sides. Sinuses should include all the sinuses. In each case, the benefit is a single amount for the region examined.

11.3.11 G.I. AND G.U. TRACT

Broad terms such as "upper gastro-intestinal tract", "barium swallow", "barium meal", etc. should be discarded in favour of the exact anatomical regions examined.

a) A scout film taken on the same day as an intravenous pyelogram or gastro-intestinal examination shall be considered as part of that examination. Special scout films ordered by the referring physician may be claimed as separate examinations.

b) The preliminary screening of the esophagus during a stomach and duodenum examination shall not constitute an esophogram. A complete radiographic and fluoroscopic examination of the esophagus when done with a complete and radiographic and fluoroscopic examination of the stomach and duodenum may be charged as a separate examination.

11.3.12 BREAST

When mammography is performed, ultrasound or real time scanning should not routinely be claimed.

11.3.13 INJECTIONS

Where injection of opaque material is not included as part of the radiological fee, the fee charged should be that listed under the appropriate section.

12 ANESTHESIA

12.1 For the purpose of assessment of anesthetic fees, each anesthetic shall be considered as a separate and complete procedure.

12.2 The anesthetic benefit listed is for professional services, including pre-evaluation and post-anesthetic follow-up and all immediate supportive measures.
The following are exceptions:

12.2.1 Consultations may be claimed up to but not including the date of surgery by the anesthesiologist administering the anesthetic, providing the provisions outlined in GR 4.3 are met. They may also be claimed on the day of surgery for urgent and emergent cases/circumstances only, by the anesthesiologist administering the anesthetic, where the provisions of GR 4.3 are met and where another physician or dentist who provides oral and maxillofacial surgery services (or their agent) specifically requests the anesthesiologist's evaluation, consultation or opinion prior to the surgery proceeding. Consultations may not be claimed for routine pre-operative evaluations.

12.2.2 An admission visit and hospital daily care may be claimed by a family physician functioning as an anesthetist.

12.2.3 When providing procedural sedation in the emergency department, a consultation benefit may not be claimed in addition to the procedural sedation.

12.3 In special cases where the attendance of more than one anesthetist is medically necessary, the benefit which may be claimed by each anesthetist shall be 100% of that listed for the procedure. The decision as to whether a second anesthetist is required for a procedure lies with the primary anesthetist. In cases where the primary anesthetist determines a second anesthetist is required, claims from both anesthetists must be submitted with text explaining the necessity for two anesthetists.

12.4 Insofar as multiple surgical procedures are concerned, the principles that apply to payment of surgical benefits should also apply to payment of anesthetic benefits. The exceptions to this are:

12.4.1 The surgical treatment of multiple benign skin lesions under anesthesia of less than 35 minutes duration may only be claimed according to the appropriate single anesthetic benefit.

12.4.2 The payment modifications for flaps and tissue resection procedures in reconstructive surgery do not apply to anesthetic benefits.

12.4.3 In multiple fractures treated by closed reduction, the listed anesthetic benefit for the major fracture plus 50% of the anesthetic benefit for each other fracture shall apply.

12.4.4 In cases of compound fractures requiring extensive debridement, the listed anesthetic benefit will be 50% greater.

12.4.5 If unrelated surgical procedures are performed by two physicians in a sequence in different anatomic areas utilizing the same anesthetic, the anesthetic benefit for the major procedure will be paid at 100% and the lesser at 75%.

12.4.6 Notwithstanding 12.4.5, when two physicians are operating simultaneously in different areas, only the greater anesthetic benefit may be claimed.

12.4.7 Anesthesia services for oral surgical procedures insured under the Schedule of Oral and Maxillofacial Surgery Benefits will be paid according to GR 6.9.

12.4.8 The benefits that may be claimed for a redo cardiac, thoracic or vascular anesthetic are as follows:

a) 150% of the listed anesthetic benefit if the procedure is performed entirely through a previous incision;
b) 125% if part of the procedure is performed through a previous incision.

Refer to GR 6.15.

12.4.9 Notwithstanding GR 6.9.7e), a benefit may be claimed at the full rate for each fracture, which requires open reduction, continuous traction, or extensive skeletal fixation in addition to the full benefit for the major fracture.

12.5 TIME RELEASE CLAUSE

12.5.1 Anesthetic services provided in association with an unlisted procedure shall be claimed on a time basis.

12.5.2 When no anesthetic value is listed in association with a procedure, claims shall be submitted on a time basis.

12.5.3 When multiple procedures are provided under the same anesthetic, anesthetic benefits may be claimed by time or by procedure, but not both.

12.5.4 The initial anesthetic time unit (modifiers ANEST and 2ANES) shall begin at the initiation of anesthetic service (time 0). Additional time units may not be claimed until a full five minutes has elapsed.

12.5.5 Additional time units (modifiers ANU and 2ANU) may not be claimed until a full five minutes has elapsed.

12.6 Deleted

12.7 An additional benefit of $108.34 per case (modifiers L30AN, L30AT, L30AT2, L44ANE) may be claimed for anesthetic services provided to neonates and infants under 44 weeks of conceptual age.

12.8 Deleted

12.9 An additional benefit of 25% (modifiers CAANE, CAANT and CA2AN) may be claimed for anesthetic services provided to infants of "corrected age" as defined under GR 1.25.

12.10 An additional benefit of 50% (modifier L40ANE) may be claimed for anesthetic services provided to infants of less than 40 weeks conceptual age as defined under GR 1.15.

13 SURGICAL ASSISTANCE BENEFITS

13.1 Claims for surgical assistance shall reflect the amount of time the assistant was required to assist the surgeon. Time claimed shall not exceed the anesthetic time.

13.2 Surgical assistance benefits may not be claimed if an intern or resident is the first assistant.

13.3 Benefits may not be claimed for procedures that do not routinely require the services of a surgical assistant or a 2nd surgeon for a 2nd surgical team, unless supporting information detailing unusual circumstances satisfactory to the Minister is provided. Such procedures include but are not limited to the following list:

01.01A	01.01B	01.03	01.04A	01.05A	01.09
01.12B	01.14	01.16B	01.16C	01.22	01.22A
01.22B	01.22C	01.24A	01.24B	01.24BA	01.24BB
01.32	01.34	02.84A	02.84B		
03.16A	03.21A	03.22A	03.22B	03.22C	03.26
03.29A	03.37A	03.38A	03.38B	03.38C	03.38D
03.38E	03.38F	03.38G	03.38H	03.38K	03.38M
03.38N	03.38P	03.38Q	03.38R	03.38S	03.38T
03.38X	03.41A	03.44A	03.45A	03.45B	03.52A
03.52C	03.55A	03.56A	03.63		
06.35A	06.35B	06.39A	06.39B	07.09A	07.27A
07.27B	07.29A	07.29B	07.51A	07.51C	07.53A
07.53B	07.53C	07.53D	07.53E	07.54A	07.56A
07.57A	07.57B	09.01A	09.01B	09.01C	09.01F
09.05A	09.06A	09.07C	09.11A	09.12A	09.26A
09.49A					
10.04	10.08A	10.16A	10.23	10.25	10.33A
10.33B	10.35	10.55A	10.56A	11.02	11.02A
11.81A	12.01	12.03	12.05	12.12A	12.12B
12.13A	12.21	12.23	12.24	12.31	13.4 A
13.42A	13.53A	13.55A	13.57A	13.59A	13.59B
13.59C	13.59D	13.72A	13.99A	13.99AA	13.99B
13.99BB	13.99C	13.99D	14.3 B	14.85B	
15.93A	15.93B	15.93C	15.94A	15.99A	16.2 B
16.81A	16.83A	16.83B	16.83C	16.89A	16.92A
17.03A	17.08D	17.08E	17.08K	17.1 A	17.39E
17.71A	17.81A	17.89A	18.29A	18.29B	19.81
20.55B	21.31B	21.32B	21.32D	21.41	21.42

21.69A	22.13A	22.13B	22.13C	22.39A	22.5 A
22.5 B	22.62A	22.71	22.81	23.99A	23.99C
23.99D	24.22A	24.5	24.89A	24.89B	24.91
25.1 A	25.29A	25.81A	27.4 A	27.5 A	27.7 A
27.7 C	27.73A	28.1 A	28.4 A	28.5 A	29.91
30.19A	30.19B	30.81A	30.9 A	32.01A	32.1
32.31	32.81	33.01A	33.02A	33.03A	33.21A
33.22A	33.22B	33.4 C	33.51A	33.51B	33.61A
33.76A	33.76B	33.76C	33.76D	33.76E	33.76F
33.76G	34.0 A	34.1 A	34.54A	34.89A	35.0 A
37.81	37.82A	37.82B	38.0 A	38.89A	38.89B
39.21A	39.62A	39.83A			
40.0	40.1 A	40.5	40.92A	41.29A	41.29B
42.09A	42.09B	43.1 B	43.81	43.82	43.95A
43.96A	43.96B	43.96C	43.96D	43.96E	44.01
44.22A	45.81A	45.83	45.84A	45.88A	
46.04A	46.04B	46.09B	46.09C	46.84A	46.88A
46.91	47.02B	47.03A	48.92A	48.98A	48.98B
49.0	49.61B	49.7 D	49.7 N	49.73A	49.81
49.82A	49.82B	49.83A	49.84	49.85	49.86
49.93A	49.95A	49.96A	49.96B	49.98B	49.98C
49.98D	49.98P	49.98Q	49.98R	49.98S	49.98T
49.98U					
50.4 A	50.6 B	50.71C	50.75E	50.79A	50.81A
50.81B	50.81C	50.81D	50.81E	50.82A	50.82B
50.83A	50.84A	50.84B	50.84C	50.87A	50.87B
50.87C	50.88A	50.89A	50.89B	50.89C	50.89D
50.89E	50.91B	50.91D	50.91E	50.93A	50.94D
50.94E	50.94F	50.95A	50.95B	50.96	50.97A
50.98A	50.99A	50.99D	51.52A	51.53B	51.59B
51.65A	51.65B	51.92A	51.92B	51.99A	51.99B
52.1 A	52.85A	53.42A	53.81A	53.81B	53.83A
54.21B	54.21C	54.21D	54.21E	54.89A	54.89B
54.89D	54.89E	54.89F	54.91A	54.92A	54.92B
54.92C	54.92D	54.92E	55.41A	55.41B	56.34A
56.93B	57.21A	57.92A	58.99B		
60.82C	60.89A	61.01A	61.03	61.29B	61.37A
61.39B	62.81A	62.82A	63.96B	63.99A	63.99B
63.99C	64.95A	64.97A	66.83	66.89B	66.89C
66.91B	66.91C	66.98A	67.02	67.81	67.83
67.86	67.87A	67.89A	67.93	67.96A	68.0 A
68.95	68.99A	68.99B	69.11	69.13D	69.29A
69.29B	69.29C	69.83A	69.83B	69.94	
70.1	70.2 A	70.2 B	70.2 H	70.4 F	70.4 G
70.5 A	70.5 B	71.8	71.95	71.96A	72.1 C
72.91	73.2 A	73.91	74.82A	75.64	75.83A
76.0	76.1 A	76.89A	76.91A	78.7 A	79.22
79.23A	79.29C	79.29E			

80.81	80.83B	80.85A	80.85B	81.01D	81.09
81.8	81.91A	81.96	82.12A	82.12B	82.12C
82.81A	82.91A	83.09A	83.2 B	83.7 A	84.21D
85.5 A	87.3	87.53A	87.54A	87.54B	87.55A
87.6	87.99A	87.99AA	88.02A	88.92	89.98A
91.00A	91.01A	91.01B	91.01H	91.01J	91.02A
91.02C	91.02D	91.03A	91.03B	91.04A	91.04B
91.05A	91.06B	91.06D	91.06E	91.07A	91.08B
91.08J	91.12A	91.13A	91.72	91.73A	91.73B
91.77C	91.78B	91.78C			
92.70	92.71	92.72	92.74	92.75	92.76
92.78A	92.78B	92.78C	93.91A	93.91B	95.03
95.81A	95.93	95.96A	96.01A	96.01B	96.02A
96.02B	96.11A	97.81	97.83A	97.89A	97.89B
97.96					
98.03A	98.03C	98.03E	98.04A	98.04B	98.12A
98.12B	98.12C	98.12G	98.12J	98.12K	98.12L
98.12M	98.12N	98.12Q	98.12R	98.12S	98.12T
98.12U	98.13A	98.22A	98.22B	98.6 A	98.8 A
98.81A	98.81B	98.89A	98.89B	98.89C	98.89D
98.89E	98.89F	98.89G	98.92C	98.93A	98.93B
98.96A	98.96B	98.96C	98.96D	98.98B	98.99AA

13.4 Unless otherwise specified in this Schedule, surgical assistance benefits may not be claimed for performing ultrasound monitoring and guidance or other imaging during a procedure that is being performed by another physician.

13.5 Consultation benefits (HSCs 03.08A, 03.08AZ, 03.08CV, 03.07A or 03.07AZ) or preoperative assessments (HSC 03.04M) may not be claimed in addition to a surgical assist (SA, SAQS, SSOS) for the same patient by the same physician.

14 TRAY SERVICE

14.1 A major tray service benefit may be claimed for the following procedures only when they are performed in a location other than a nursing home, general or auxiliary hospital, AACC, UCC or a facility which has a contract with a regional health authority to provide any of these insured services.

01.03	01.04A	01.05A	01.24A	01.24B	01.24BA
01.24BB	01.34	02.84A	02.84B	03.22B	03.25
07.53B	07.53D	07.53E	07.57A		
12.31	13.59C	17.08A	17.81A		
21.42	21.69A	22.13A	22.13B	22.13C	22.5 A
22.51A	22.62A	22.71	22.81	25.1 A	25.29A
25.39D					
32.01A	32.81	33.02A	33.22B	34.0 A	34.1 A
34.89A	37.82A	38.89A	39.21A	39.62A	39.83A
39.83A					

40.92A	46.91				
50.4 A	50.97A	52.1 A	52.11A	52.13	56.93B
60.24C	61.01B	61.03	61.29B	61.37A	61.39B
66.91A					
70.1	70.5 A	72.91	75.64	79.23A	79.29E
82.81A	82.91A	83.7 A	87.3	87.55A	89.37A
89.37B	89.41A	89.41B	89.42A		
93.39B	93.39C	95.02A	95.09A	95.81A	97.11B
97.83A	97.89B	98.04A	98.6 A	98.6 B	98.12A
98.12B	98.12C	98.12H	98.12J	98.12M	98.12N
98.12Q	98.12R	98.12T	98.14A	98.22A	98.22B
98.81A	98.96A	98.96B	98.96C	98.96D	

14.2 MINOR TRAY SERVICE

A minor tray service benefit may be claimed for the following procedures only when they are performed in a location other than a nursing home, general or auxiliary hospital, AACC, UCC or a facility which has a contract with a regional health authority to provide any of these insured services.

07.53C	07.56A	07.57B	10.16A	11.23A	12.01
12.21	13.53B	13.59E	13.59F	13.59H	13.59J
13.59K	13.59L	13.59N	13.99BB	16.89B	16.89C
16.89D	17.71A	17.71B	18.29E	19.81	
21.31A	21.41	21.32D	21.69C	23.99D	24.91
30.19A	32.96A	32.96B	33.01A	33.03A	33.21A
33.22A	33.61A	35.0 A	37.81	37.91A	38.0 A
39.91B					
43.0 B	50.98A	51.92A	53.81B		
61.01A	67.93	70.5 B	71.95	73.91	78.7 A
79.22					
80.83B	81.8	93.91A	93.91B	94.01B	94.04
95.03	95.93	95.94A	95.94B	95.96A	97.81
97.89A	98.01A	98.03A	98.03B	98.03C	98.03E
98.04B	98.04C	98.12K	98.12S		

14.3 MULTIPLE TRAY SERVICE

If multiple procedures listed under GRs 14.1 and 14.2 are performed during the same encounter in a location other than a nursing home, general or auxiliary hospital, AACC, UCC or a facility which has a contract with a regional health authority to provide any of these insured services, the following applies:

14.3.1 For the same anatomical area (example - 3 moles removed from the face), only one tray may be claimed except when the condition relates to suspected cancer or infection, in which case, if required, additional tray(s) may be claimed at 50%.

14.3.2 For different anatomical areas, the tray for the initial procedure may be claimed at 100% and if required, the tray for each additional procedure may be claimed at 50%.

14.3.3 Benefits for additional trays may not exceed the benefit listed for one major tray.

15 OFF HOURS PREMIUM BENEFITS

15.1 In the case of physicians working exclusively in a hospital setting on either a full-time basis or as a part of their normal practice for a specified period of time (e.g. weekly hospital rotations among a practice group) off hours premium benefits may be claimed in accordance with the GRs for those claims as long as the claiming physician is the attending physician or is primarily responsible for the patient's care, or is claiming concurrent care in accordance with GR 4.8. In the case of physicians working in an AACC or UCC, off hours premium benefits may be claimed in accordance with the GRs for those claims as long as the claiming physician is the attending physician.

15.2 Deleted.

15.3 UNSCHEDULED SERVICES/SPECIAL CALLBACKS - AACC, UCC, HOSPITAL INPATIENT, OUTPATIENT AND EMERGENCY DEPARTMENTS

Benefits for UNSCHEDULED services (modifier SURC) and special callback HSCs 03.03LA, 03.03MC, 03.03MD, 03.05P, 03.05QA, 03.05QB and 03.05R are intended to cover a degree of disruption that a physician would have to experience to provide such services during:
- the evening on weekdays (1700 - 2200 hours),
- the day and evening on weekends and statutory holidays (0700 - 2200 hours)
- any night of the week (2200 - 0700 hours)

15.4 In situations where the physician initiates the service, the unscheduled service or special callback benefits may not be claimed. Claims may however, be made for the after hours time unit premium benefit (modifier SURT) under 03.01AA. See GR 15.13.

15.5 Only one unscheduled service or special callback benefit may be claimed for each encounter with a patient. In the event of a special callback, the following visit services may be claimed in addition:
HSC 03.02A, 03.03A, 03.03AZ, 03.03B, 03.03BZ, 03.04A, 03.04AZ, 03.03DF or 03.03EA.

15.6 The unscheduled service and special callback benefit must be claimed according to the time at which the encounter commences and not from the time of the call for attendance.

15.7 Claims for Unscheduled Services/Special Callback Benefits

15.7.1 Claims for the unscheduled service benefit (modifier SURC) must meet all of the following conditions:
a) a special call for attendance is made on the patient's behalf;
b) the physician responds to such a call on an unscheduled basis outside of his/her normal working hours;
c) the patient is attended on a priority basis;
d) there is direct attendance by the physician.

15.7.2 Claims for special callbacks must meet all of the following conditions:
a) a special call for attendance is made on the patient's behalf;
b) the physician responds to such a call from outside the hospital, auxiliary hospital, nursing home, AACC or UCC on an unscheduled basis;
c) the patient is attended on a priority basis;
d) there is direct attendance by the physician.

15.8 Special callback benefits may not be claimed for subsequent patients seen during the same callback or in association with another service during the same encounter. However:
a) HSC 03.03AR may be claimed for second and subsequent hospital inpatients.
b) for second and subsequent emergency/outpatients, or AACC or UCC patients seen during the same callback, see GR 5.2.3.
c) HSCs 03.03DF and 03.03EA may be claimed in addition to a callback in accordance with GR 15.5.

15.9 The unscheduled service benefit (modifier SURC) may be claimed for the services outlined in GRs 15.9.1 through 15.9.3.

15.9.1 selected "V" category code services:
a) consultations, including telehealth (except those provided using store and forward videotechnology);
b) intensive care unit visits (HSC 03.05A);
c) psychiatric mental status determination requiring complete mental health status examination and investigation (HSC 08.11A);
d) for complex patient, requiring complete mental status examination and investigation (HSC 08.11C);
e) certification under the Mental Health Act (HSC 08.12A);
f) trauma assessment, multiple trauma, severely injured patient (HSC 13.99GA);
g) hyperbaric oxygen therapy detention time (HSC 13.99I);
h) medical emergency detention (HSC 13.99J);
i) management of complex labor, per 15 minutes (HSC 13.99JA);
j) donor maintenance prior to cadaveric harvesting of organs (HSC 13.99L);
k) examination and crisis counseling for sexual/physical abuse (HSC 13.99V);
l) attendance at delivery (HSC 87.98E).

15.9.2 radiology, pathology and other diagnostic and therapeutic services if the physician is directly involved in the provision of services of an invasive nature;

15.9.3 procedures including surgical assists, obstetrical deliveries, anesthesia, major surgery and minor surgery.

15.9.4 The unscheduled service benefit (modifier SURC) may also be claimed for services outlined in GRs 15.9.1 through 15.9.3 when provided to second and subsequent patients seen during the same special call for attendance at the same facility.

15.10 The unscheduled service benefit (modifier SURC) may not be claimed for:

15.10.1 stand-by time;

15.10.2 services provided by physicians who are on-site and working a scheduled rotation duty shift in a hospital emergency department, AACC or UCC or providing first call coverage in an emergency department with greater than 25,000 visits per year;

15.10.3 additional procedures, i.e., those performed in association with another procedure;

15.10.4 non-invasive diagnostic procedures;

15.10.5 "V" category code services except for those listed under GR 15.9.1; and

15.10.6 Services included in the following list unless supporting information detailing unusual circumstances satisfactory to the Minister is provided.

03.21A	03.22A	03.22B	03.25	03.29A	07.29B
07.51A	07.51C	07.54A	07.56A	13.42A	13.53A
13.57A	13.59A	13.59B	13.59H	13.59J	17.81A
21.69A	22.13B	22.13C	22.71	22.81	23.99D
24.91	26.91A	29.91	30.19A	30.81A	32.1
32.81	33.21A	33.22B	33.51A	37.82A	37.82B
38.89A	39.21A	39.62A	39.83A		
40.92A	41.29A	50.97A	51.92A	52.1 A	52.11A
52.11B	52.12	52.13			

60.82C	61.29B	61.39B	69.83A	69.83B	73.2 A
75.83A	76.1 A	79.22	79.23A	79.29E	
81.91A	82.81A	82.91A	83.2 B	83.7 A	87.99B
95.81A	95.94A	95.94B	97.11A	98.12A	98.12B
98.12C	98.12J	98.12K	98.12L	98.12M	98.12N
98.12Q	98.12R	98.12T	98.8 A	98.81A	98.81B
98.99AA					

15.11 MAXIMUMS FOR SPECIAL CALLBACKS

15.11.1 A maximum of five (5) special callbacks, either HSC 03.03KA, 03.05N or any combination thereof may be claimed, per physician, in any given weekday day. The weekday day is defined as Monday - Friday (0700 - 1700 hours).

15.11.2 A maximum of five (5) HSC 03.03LA, 03.05P or any combination thereof may be claimed, per physician, in any given weekday, Monday - Friday (1700 - 2200 hours).

15.11.3 A maximum of fifteen (15) HSC 03.03LA, 03.05R or any combination thereof may be claimed, per physician, on any day of the weekend or statutory holiday, (0700 - 2200 hours).

15.11.4 A maximum of two (2) HSC 03.03MC, 03.05QA or any combination thereof may be claimed, per physician, any day, (2200 - 2400 hours).

15.11.5 A maximum of seven (7) HSC 03.03MD, 03.05QB or any combination thereof may be claimed, per physician, any day, (2400 - 0700 hours).

15.11.6 Deleted

15.11.7 A maximum of five (5) special callbacks to a closed office, HSC 03.03ME, may be claimed, per physician, in any given weekday, Monday - Friday (0000 - 2400 hours).

15.11.8 A maximum of ten (10) special callbacks to a closed office, HSC 03.03MF may be claimed, per physician, on any day of the weekend or statutory holiday, (0000 - 2400 hours).

15.12 Deleted

15.12.1 Deleted

15.12.2 Deleted

15.12.3 Deleted

15.12.4 Deleted

15.12.5 Deleted

15.12.6 Deleted

15.12.7 Deleted

15.12.8 Deleted

15.12.9 Deleted

15.13 AFTER HOURS TIME PREMIUM - HOSPITAL INPATIENT, OUTPATIENT AND EMERGENCY DEPARTMENTS, AACCs, UCCs, AUXILIARY HOSPITALS AND NURSING HOMES

15.13.1 Benefits for the AFTER HOURS TIME PREMIUM (modifier SURT) are intended to provide physicians with compensation for services provided after hours during:
- the evening on weekdays (1700 - 2200 hours),
- the day and evening on weekends and statutory holidays (0700 - 2200 hours),
- any night of the week (2200 - 0700 hours).

15.13.2 The after hours time premium modifier applies to both scheduled and unscheduled services. In the case of unscheduled services, the unscheduled services modifier will also apply according to GRs 15.3 through 15.10.6.

15.13.3 Deleted

15.13.4 The after hours time premium modifier is to be claimed on a per 15 minute basis beginning at the time of contact with the patient and may only be claimed for direct patient care time related to the provision of an insured service. The after-hours time premium units may not be claimed for stand by time, e.g. time spent waiting for results of diagnostic tests.

15.13.5 Time for the after hours time premium may be determined on a cumulative basis, and claimed according to the time period(s) in which the majority of the service occurred. HSC 03.01AA should be used to claim the after-hours time modifier for all services.

15.13.6 In the event that one 15 minute period covers two time periods, the modifier claimed will be based on the time period where the majority of the 15 minute period occurred.

15.13.7 In the event that the time spent with the patient covers more than one time period, additional modifiers may be claimed, each according to the time spent with the patient in that particular time period.

15.13.8 Deleted

15.13.9 The after hours time premium modifier may not be claimed for:
- stand-by time;
- non-invasive diagnostic procedures.

15.13.10 The maximum number of after hours time premium modifiers per hour, per physician is 4.

16 Deleted

17 TELEHEALTH

17.1 TELEHEALTH EXAMINATION - DEFINITION
Telehealth examination means an examination of a patient by the consultant at the receiving site, using "telehealth services" as defined under GR 1.10 but does not include the "physical examination" requirements referred to under GR 4.1.

17.2 Deleted

17.3 Deleted

17.4 "Store and forward" videotechnology applies only to teledermatology telehealth services and teleophthalmology consultations (HSC 03.09B).

17.4.1 Deleted

17.4.2 Services provided using store and forward videotechnology are not eligible for unscheduled service benefits.

17.5 Telehealth services provided at the request of a non-physician other than a midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner may not be claimed as consultations; payment will be made at the non-referred visit rate.

17.6 Services claimed using the telehealth modifier must meet all of the requirements outlined in the applicable GR's except as outlined in GR 17.1.

18 BODY MASS INDEX (BMI)

18.1 The Body Mass Index (BMI) modifier may be claimed for selected procedures, obstetrical services, anesthesia, second qualified surgeon and surgical assistant services provided in any location when the following criteria are met:

a) An adult patient has a body mass index of 40 or more.
b) A patient under 18 years of age who is above the 97th percentile for BMI on an approved pediatric growth curve.
c) The following HSCs are only eligible for the BMI modifier when the service is provided under general, spinal, epidural anesthetic or regional nerve block performed in an operating room, day surgery or surgical suite:
98.11A, 98.11B, 98.11C, 98.11D, 98.11E, 98.11F, 98.22A, 98.22B.

19 DAILY PATIENT VOLUME PAYMENT RULES

19.1 Daily patient volume payment rules will apply to visit services with a "V" category code (excluding HSC 03.01AD, 03.01N, 03.03CV, 03.03FV, 03.05LB, 03.08CV, 08.19CV, 08.19CW, 08.19CX, 08.44A, 08.44B, 08.44C, 08.44D, 13.59V, 13.59VA, 13.82A, 13.99AC, 13.99O and 13.99OA) that are provided in an office, home, or a non-registered facility.

Excluding Grande Prairie and Fort McMurray, the daily patient volume payment rules will not apply to services provided in communities that are eligible for variable fee payments under the Rural Remote Northern Program.

The total of all billings for eligible category "V" codes that are accepted for payment under the Alberta Health Care Insurance Plan will be calculated for each practitioner for each calendar day. When the daily total exceeds 50, the practitioner's payment on the category "V" codes that exceed 50 will be discounted by 50 percent. When the daily total exceeds 65, the practitioner's payment on the category "V" codes that exceed 65 will be discounted by 100 percent.

Services will be assessed and payment/discounts will be applied to services in the order in which they are accepted for payment by the Alberta Health Care Insurance Plan.