Alberta Government

Bulletin

Alberta Health Care Insurance Plan

Number: Med 204	Date: November 1, 2018	Page: 1 of 1
Subject: Schedule of Medical Benefits Amendments effective November 1, 2018	**Reference:** Schedule of Medical Benefits	

To: all physicians and billing staff

Amendments have been made to the Schedule of Medical Benefits effective November 1, 2018. Please refer to the Bulletin Attachments A, B and C for details. Amended text is shown in bold print and underlined in the attachments.

- Attachment A contains amended General Rules
- Attachment B contains new, amended and deleted Health Service Codes
- Attachment C contains new Modifiers

The November 1, 2018 Schedule has been posted online at http://www.health.alberta.ca/professionals/fees.html

The Alberta Medical Association website at www.albertadoctors.org will also contain a link to the schedule.

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Attachment A
Amended General Rules

Amended General Rules

- GR 4.4.8 is amended to add HSCs 01.12B, 03.04Q and 03.22C and to remove HSCs 01.12, 03.25 and 54.21A.

- GR 6.5 is amended to add HSCs 03.39A, 03.39B, 03.44A, 09.02E, 09.13G and 09.13H.

- GR 6.9.7 is amended to remove HSC 65.9 A from 6.9.7 e) and to add HSCs 56.93F and 65.9 E to Group C under 6.9.7 g) and to remove HSCs 56.51A and 56.93.

- GR 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 up to **100%** of the benefit listed for such fractures.

- GR 13.3 is amended to add HSCs 01.12B and 03.22C and to remove HSCs 01.12, 03.25 and 54.21A.

- GR 14.2 is amended to add HSC 17.71B.

Attachment B

New, amended and deleted Health Service Codes

New Health Service Codes

■ **01.12B** Other nonoperative esophagoscopy, rigid

■ **03.39A** 24-hour ambulatory blood pressure monitoring (ABPM), Interpretation
NOTE: May only be claimed by internal medicine specialists.

■ **03.39B** 24-hour ambulatory blood pressure monitoring (ABPM), technical
NOTE: May only be claimed by internal medicine specialists.

■ **03.7 BA** Medical Assistance in Dying – Determination Phase, full 15 minutes or major portion thereof for the first call when only one call is claimed
NOTE:
1. May only be claimed for patient management for Medical Assistance in Dying.
2. Services related to the Determination Phase include:
   a. Patient assessment for Medical Assistance in Dying;
   b. Obtaining and reviewing medical records;
   c. Reviewing but not waiting for lab and other diagnostic information, and
   d. Completion of appropriate documents and forms.
3. All services must be provided in accordance with the CPSA standards for Medical Assistance in Dying.
4. May not be claimed in addition to a visit, consultation or assessment.
5. May not be claimed for travel time.
6. The total time spent during the Determination Phase may be calculated on a cumulative basis over the course of several hours or several days.
7. The patient's record must include a detailed summary of all services provided including a summary of time spent per day per activity.

New Health Service Codes (con't)

■ **03.7 BB** Medical Assistance in Dying – Action Phase, full 15 minutes or major portion thereof for the first call when only one call is claimed

NOTE:
1. May only be claimed for patient management for Medical Assistance in Dying.
2. Services related to the Action Phase include:
   a. patient visit and assessment,
   b. Pharmacy visit,
   c. Patient care advice to pharmacist, providing physician and nurse practitioner,
   d. Review and administration of medication,
   e. Coordination of procedure, and
   f. Completion of appropriate documents and forms.
3. All services must be provided in accordance with the CPSA standards for Medical Assistance in Dying.
4. May not be claimed in addition to a visit, consultation or assessment.
5. May not be claimed for travel time.
6. The total time spent during the Action Phase may be calculated on a cumulative basis over the course of several hours or several days.
7. The patient's record must include a detailed summary of all services provided including a summary of time spent per day per activity.

■ **03.7 BC** Medical Assistance in Dying – Care After Death Phase, full 15 minutes or major portion thereof for the first call when only one call is claimed

NOTE:
1. May only be claimed for patient management for Medical Assistance in Dying.
2. Services related to the Care After Death Phase include:
   a. Reporting of event;
   b. Post event arrangements,
   c. Completion of death certificate, and
   d. Completion of appropriate documents and forms.
3. All services must be provided in accordance with the CPSA standards for Medical Assistance in Dying.
4. May not be claimed for travel time.
5. The total time spent during the Care After Death Phase may be calculated on a cumulative basis over the course of several hours or several days.
6. The patient's record must include a detailed summary of all services provided including a summary of time spent per day per activity.

New Health Service Codes (con't)

■ **17.71B** Femoral Nerve Block – injection with or without ultrasound
NOTE: 1. May not be claimed for services related to chronic pain management or treatment.
2. May not be claimed in addition to any other anesthetic services by the same physician.
3. May be claimed in addition to a visit or consultation by the same physician.
4. May not be billed with a visit if another physician has provided and claimed a visit on the same date of service in the same location.

■ **56.93F** Placement of gastric band including port placement

■ **65.11A** Repair of inguinal hernia – with or without incarceration, obstruction or strangulation, includes the use of mesh if used

■ **65.9 E** Repair of diaphragmatic hernia, abdominal or thoracic approach, anti-reflux procedure
That for recurrent esophagitis, following a previous repair

■ **89.0 B** Reconstruction of sternum using plates and screws
NOTE: May not be claimed for closure of sternum for routine cardiac procedures.

Amended Health Service Codes

01.24B	01.24BA	01.24BB	03.01LJ	03.01LK	03.01LL	03.01NG
03.01NH	03.01NI	03.01NL	03.01O	03.01S	03.01T	03.03DG
03.03FA	03.04J	03.04Q	03.05A	03.05G	03.05GA	03.05JB
03.05JR	03.08H	03.08I	03.08M	08.19K	13.57A	13.99GA
13.99JA	16.89D	21.71	22.13A	22.13B	22.13C	22.32A
22.4 A	23.99A	25.55A	26.2 B	26.25B	26.34A	26.71
27.72A	28.72B	28.79B	29.02A	43.0 A	50.24B	50.94D
50.94E	52.2	52.31A	52.31B	52.31C	52.31D	53.53A
54.6	55.8 B	55.9 AA	56.2	56.4 A	56.93D	56.93E
57.42A	57.7	62.12C	65.61A	66.3 A	66.4 A	66.83
91.01M	92.78C	93.91B	95.93	95.96A	96.02A	97.43

■ **01.24B –** Amend Note 1 to read as follows:

01.24B Flexible proctosigmoidoscopy, diagnostic only
NOTE: 1. HSCs 13.99AE, 57.13A, 57.21A, 57.21B, **57.21C,** 58.99C and 58.99D may be claimed in addition.

■ **01.24BA** – Amend Note 1 to read as follows:

01.24BA Flexible proctosigmoidoscopy for screening of patients considered to be of high risk for colon cancer due to a family history of Familial Adenomatous Polyposis (FAP)
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B**, 57.21C** and 58.99D may be claimed in addition.

■ **01.24BB** – Amend Note 1 to read as follows:

01.24BB Flexible proctosigmoidoscopy for screening of patients who are considered to be of average risk for colon cancer
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B**, 57.21C** and 58.99D may be claimed in addition.

■ **03.01LJ** – Amend description to read as follows:

03.01LJ Physician**, nurse practitioner, midwife** or podiatric surgeon to physician telephone or telehealth videoconference or secure videoconference consultation, consultant, weekdays 0700 to 1700 hours

Amended Health Service Codes (con't)

■ **03.01LK** – Amend description to read as follows:

03.01LK Physician**, nurse practitioner, midwife** or podiatric surgeon to physician telephone or telehealth videoconference or secure videoconference consultation, consultant, weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours

■ **03.01LL** – Amend description and notes to read as follows:

03.01LL Physician**, nurse practitioner, midwife** or podiatric surgeon to physician telephone or telehealth videoconference or secure videoconference consultation, consultant, any day 2200 to 0700 hours

NOTE:
1. HSCs 03.01LJ, 03.01LK, 03.01LL may only be claimed when initiated by the referring physician**, nurse practitioner, midwife** or podiatric surgeon.
2. The consultant may not claim a major consultation or procedure for the same patient for the same condition within 24 hours unless the patient was transferred from an outside facility and advice was given on management of that patient prior to transfer.
3. May only be claimed when the consultant has provided an opinion and recommendations for patient treatment as well as management after reviewing pertinent family/patient history and history of the presenting complaint as well as discussion of the patient's condition and management after reviewing laboratory and other data where indicated. It is expected that the purpose of the call will be to seek the advice of a physician more experienced in treating the particular problem in question, and that the referring physician**, nurse practitioner, midwife** or podiatric surgeon intends to continue to care for the patient.
4. May not be claimed for situations where the purpose of the call is to:
   - arrange for an expedited consultation or procedure within 24 hours except when the conditions in note 2 are met
   - arrange for laboratory or diagnostic investigations
   - discuss or inform the referring physician or podiatric surgeon of results of diagnostic investigations.
5. A maximum of two (any combination of HSC 03.01LJ, 03.01LK, 03.01LL) claims may be claimed per patient, Per physician, per day.

Amended Health Service Codes (con't)

6. Documentation must be recorded by both the referring physician**, nurse practitioner, midwife** or the podiatric surgeon and the consultant in their respective records.
7. Telehealth videoconferences may only be claimed when all participants are participating in the videoconference from regional telehealth facilities.
8. Claims for secure videoconference may only be claimed when the service is provided using a secure videoconference system that is in compliance with the CPSA guidelines on secure electronic communication and when the physician/clinic has submitted a Privacy Impact Assessment for this service accepted by the Office of the Privacy Commissioner of Alberta.
9. **Advice to nurse practitioners may only be claimed if the nurse practitioner is in autonomous practice or working at a nursing station where no physician is present.**
10. **Advice to midwives may be claimed if the midwife is in independent practice or working at a midwifery center.**

■ **03.01NG** – Amend description to read as follows:

03.01NG Patient care advice to paramedic - pre hospital patch, assisted living/designated assisted living and lodge staff, active treatment facility worker for hospital in-patient, long term care worker for patients in a long term care facility, nurse practitioner, hospice worker, home care worker**, midwife** or public health nurse weekdays 0700 to 1700 hours, provided via telephone or other telecommunication methods, in relation to the care and treatment of a patient

■ **03.01NH** – Amend description to read as follows:

03.01NH Patient care advice to paramedic - pre hospital patch, assisted living/designated assisted living and lodge staff, active treatment facility worker for hospital in-patient, long term care worker for patients in a long term care facility, nurse practitioner, hospice worker, home care worker**, midwife** or public health nurse weekdays 1700 to 2200 hours, weekends and statutory holidays, 0700 to 2200 hours, provided via telephone or other telecommunication methods, in relation to the care and treatment of a patient

Amended Health Service Codes (con't)

■ **03.01NI** – Amend description and notes to read as follows:

03.01NI Patient care advice to paramedic - pre hospital patch, assisted living/designated assisted living and lodge staff, active treatment facility worker for hospital in-patient, long term care worker for patients in a long term care facility, nurse practitioner, hospice worker, home care worker**, midwife** or public health nurse any day 2200 to 0700 hours, provided via telephone or other telecommunication methods, in relation to the care and treatment of a patient

NOTE: 1. Active treatment facility worker may include registered: nurse, licensed practical nurse, **midwife,** occupational therapist, physiotherapist, speech language pathologist, social worker, pharmacist, psychologist, recreational therapist or respiratory therapist.

2. Long term care worker/hospice worker may include registered: nurse, licensed practical nurse, occupational therapist, physiotherapist, speech language pathologist, social worker, pharmacist, psychologist or recreational therapist.

3. Advice to nurse practitioners may only be claimed if the nurse practitioner is in **autonomous** practice or working at a nursing station where no physician is present. Advice to a public health nurse may only be claimed if the public health nurse is employed by AHS and working in an AHS health unit.

4. Advice to midwives may be claimed if the midwife is in independent practice or working at a midwifery center.

5. In the case of long term care or active treatment facility worker, claims may only be submitted when the physician is outside the facility where the patient is located.

6. May be claimed for advice given to **midwife,** hospice worker, home care worker or public health nurse in person as well as advice by telephone or other telecommunication methods.

7. HSCs 03.01NG, 03.01NH and 03.01NI are to be claimed Using the Personal Health Number of the patient.

8. May only be claimed when the call is initiated by the long term care worker, assisted living/designated assisted living or lodge staff member, active treatment facility worker, home care worker, nurse practitioner, hospice worker, **midwife,** public health nurse or

paramedic.

Amended Health Service Codes (con't)

9. In the case of a long term care or hospice patient the call may be initiated by the physician if it is in response to receipt of diagnostic or other information that would affect the patient's treatment plan.

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

11. A maximum of two (any combination of HSC 03.01NG, 03.01NH, 03.01NI) claims may be made per patient, per physician, per day.

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

HSCs 03.01LJ, 03.01LK, 03.01LL are intented for situations when the consulting physician is unfamiliar with the patient and in order to provide advice, the consulting physician must complete a history or assessment of the patient. If the consulting physician has an existing relationship with the patient, they must bill either HSC 03.01NG, 03.01NH, 03.01NI when providing advice to the appropriate referring practitioner.

■ **03.01NL** – Amend Note 2 to read as follows:

03.01NL Patient care advice to active treatment facility worker in relation to a patient receiving outpatient IV medication day treatment, any day 2200 to 0700 hours

NOTE: 2. May only be claimed by **hematology,** infectious disease specialists, internal medicine and rheumatologists.

■ **03.01O** – Amend description and notes to read as follows:

03.01O Physician **or Nurse Practitioner** to Physician secure E-Consultation, consultant

NOTE: 1. May only be claimed when both the referring physician **or referring nurse practitioner and the consulting physician** exchange communication using secure electronic communication that is in compliance with the CPSA guidelines on secure electronic communication and when the physician/**nurse practitioner/**clinic has submitted a Privacy Impact Assessment for this service acceptable to the Office of the Privacy Commissioner of Alberta.

2. This service is only eligible for payment if the consultant physician has provided an opinion/advice and/or recommendations for patient treatment and/or management within thirty (30) days from the date of the e-consultation request.

3. May only be claimed when initiated by the referring physician **or referring nurse practitioner**.

Amended Health Service Codes (con't)

4. The consultant may not claim a major consultation, physician to physician phone call, or procedure for the same patient for the same condition within 24 hours of receiving the request for an e-consultation unless the patient was transferred from an outside facility and advice was given on management of that patient prior to transfer.
5. May only be claimed when the consultant has provided an opinion and recommendations for patient treatment as well as management after reviewing pertinent family/patient history, history of the presenting complaint as well as laboratory and other data where indicated. It is expected that the purpose of the communication will be to seek the advice of a physician more experienced in treating the particular problem in question, and that the referring physician **or referring nurse practitioner** intends to continue to care for the patient.
6. May not be claimed for situations where the purpose of the communication is to:
   a. arrange for an expedited consultation or procedure within 24 hours except when the conditions in note 4 are met
   b. arrange for laboratory or diagnostic investigations
   c. discuss or inform the referring physician of results of diagnostic investigations.
7. Documentation of the request and advice given must be recorded by the consultant in their patient records.
8. This service may not be claimed for transfer of care alone.
9. **Advice to nurse practitioners may only be claimed if the nurse practitioner is in autonomous practice or working in a nursing station where no physician is present.**

Amended Health Service Codes (con't)

■ **03.01S** – Amend Note 7 to read as follows:

03.01S Physician to patient secure electronic communication
NOTE: 7. A maximum of **fourteen** 03.01S per calendar week per physician may be claimed.

■ **03.01T** – Amend Note 5 to read as follows:

03.01T Physician to patient secure videoconference
NOTE: 5. A maximum of **fourteen** 03.01T per calendar week per physician may be claimed.

■ **03.03DG** – Amend Price List

03.03DG Complex pediatric hospital visit per full 15 minutes

CALL M15			V
1	For Each Call Pay Base At	100%	
2-10	For Each Call Pay Base At	**70**%	

■ **03.03FA** – Amend Note 2 to read as follows and add skills to Price List:

03.03FA Prolonged repeat office or scheduled outpatient visit in a regional facility, referred cases only, full 15 minutes or portion thereof for the first call when only one call is claimed
NOTE: 2. May only be claimed by pediatrics (including subspecialties) and clinical immunology and allergy for patients 18 years of age and under, or by cardiology, endocrinology/metabolism, gastroenterology, infectious diseases, internal medicine, hematology, medical genetics, **medical oncology, neurology,** physiatry, respiratory medicine, rheumatology, urology and vascular surgery (no age restriction).

Amended Health Service Codes (con't)

■ **03.04J** – Amend Note 2 and 7 to read as follows:

03.04J Development, documentation and administration of a comprehensive annual care plan for a patient with complex needs

NOTE: 2. May only be claimed by the most responsible primary care general practitioner **who has an established relationship with the patient and where the physician intends to provide ongoing care and management of the patient**.

7. "Care plan" means a single document that meets the following criteria:
   a) Must be communicated through direct contact with the patient and/or the patient's agent.
   b) Must include clearly defined goals which are mutually agreed upon between the patient and/or the patient's agent and the physician.
   c) Must include a detailed review of the patient chart, current therapies, problem list and past medical history.
   d) Must include any relevant information that may affect the patient's health or treatment options, such as demographics (education, income, language) or lifestyle behaviors (addictions, exercise, sleep habits, etc.)
   e) Must incorporate the patient's values and personal health goals in the care plan, with respect to his or her complex needs.
   f) Must outline expected outcomes as a result of this plan, including end-of-life issues when clinically appropriate.
   g) Must identify other health care professionals that would be involved in the care of the patient and their expected roles.
   h) Must include confirmation that the care plan has been communicated verbally and in writing to the patient and/or the patient's agent.
   i) Must be signed by **both** the physician and the patient or patient's agent. **The comprehensive annual care plan is only billable if the care plan form on record is signed by both the physician and the patient or patient's agent.**
   j) **The signed copy of the care plan form m**ust be retained in the patient's medical record.

Amended Health Service Codes (con't)

■ **03.04Q** – Post surgical cancer surveillance examination

A referral is required for this service. Cannot be self-referred.

■ **03.05A –** Amend Note 1 and add Note 5 to read as follows:

03.05A Intensive care unit visit per 15 minutes
NOTE: 1. Time spent with a patient **must** be claimed on a Cumulative basis per day.
5. Conditions for unscheduled services apply as per GR 15.7.

■ **03.05G** – Amend description to read as follows:

03.05G **Initial assessment of** newborn

■ **03.05GA –** Amend Price List

03.05GA Care of healthy newborn in hospital (subsequent days)
SKLL PED Replace Base V

■ **03.05JB –** Amend notes to read as follow:

03.05JB Formal, scheduled family conference relating to a specific patient, per 15 minutes or major portion thereof
NOTE: 1. May not be claimed at the same encounter as **a visit**.
2. May be claimed to a maximum of 12 calls or **3** hours per year (April 1 to March 31), per patient, per physician.

■ **03.05JR** – Amend Note 1 to read as follows:

03.05JR Physician telephone call directly to patient, to discuss patient management/diagnostic test results
NOTE: 1. A maximum of **14** telephone calls per physician, per calendar week may be claimed.

Amended Health Service Codes (con't)

■ **03.08H** – Amend description to read as follows:

03.08H Formal major neuro-ophthalmology consultation**, including complex consultations of orbit or oncology**

■ **03.08I –** Amend description to read as follows and add skills to Price List:

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

Amended Health Service Codes (con't)

■ **03.08M** – Amend description to read as follows:

03.08M Extended uro-gynecology, **pediatric gynecological,** gyne-oncology, reproductive endocrinology or perinatology consultation, per 15 minutes or major portion thereof

■ **08.19K** – Amend Note 5 to read as follows:

08.19K NOTE: 5. HSC 08.19K may be claimed to a maximum of 2 calls per patient, per **calendar** week, per physician.

■ **13.57A** – Amend description to read as follows:

13.57A Iontophoresis**, ionization or gluing** or ionization of corneal ulcer

■ **13.99GA** – Amend Note 6 to read as follows:

13.99GA Trauma assessment, multiple trauma, severely injured patient
NOTE: 6. Following the **seventh** day of trauma care, the appropriate level of hospital care should be claimed using HSC 03.03D.

■ **13.99JA** – Amend Note 7 and the Price List to read as follows:

13.99JA Management of complex labour, per 15 minutes
NOTE: 7. A maximum of **twelve** 15 minute units may be claimed per patient per pregnancy.

CALL M15			V
1-**12**		For Each Call Pay Base At	100%
SURC EV	Y	Increase By	48.70
SURC NTAM	Y	Increase By	116.83
SURC NTPM	Y	Increase By	116.83
SURC WK	Y	Increase By	48.70

■ **16.89D** – Amend Note 3 to read as follows:

16.89D Percutaneous facet joint injection - Lumbar/Sacral
NOTE: 3. HSCs 16.89B, 16.89C and 16.89D may not be claimed in addition to HSCs 13.5**3**B, 13.59J, 92.78B or 92.78C.

■ **21.71** – Amend Price List to add BMIPRO modifier:

21.71 Dacryocystorhinostomy (DCR)

BMI	**BMIPRO**	**Y**	**Increase By**	**25%**

■ **22.13A** – Amend Price List to add L10 and CALL10 modifiers:

22.13A Excision of eyelid lesion requiring pathology analysis

AGE L10	**Increase Base To 130%**
CALL CALL10	
1	**For Each Call Pay Base At 100%**
2-2	**For Each Call Pay Base At 75%**

Amended Health Service Codes (con't)

■ **22.13B** - Amend Price List to add L10 and CALL10 modifiers:

22.13B Chalazion –surgical removal

AGE L10 Increase Base To 130%
CALL CALL10
1 For Each Call Pay Base At 100%
2-2 For Each Call Pay Base At 75%

■ **22.13C** – Amend description and note to read as follows:

22.13C **Non cosmetic e**xcision of benign tumor of eyelid not requiring pathology analysis**, for functional reasons including obstruction of visual axis, tearing, inflammation or lid malposition**
NOTE: For services requiring pathology analysis see HSC 22.13A.

■ **22.32A** – Amend Price List to add BMIPRO and REDO modifiers

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

BMI BMIPRO Y Increase By 25%
REDO REOP Y Increase Base To 125%

■ **22.4 A** - Amend Price List to add L10 and CALL10 modifiers:

22.4 A Eyelid ptosis repair requiring surgery on eyelid retractors – muller, levator, frontalis and/or lower lid equivalent

AGE L10 Increase Base To 130%
CALL CALL10
1 For Each Call Pay Base At 100%
2-2 For Each Call Pay Base At 75%

■ **23.99A** – Amend Price List to increase the amount paid for 2-6 calls:

23.99A Strabismus repair, one muscle

CALL NBRSER

1	For Each Call Pay Base At	100%
2-6	For Each Call Pay Base At	**75**%

■ **25.55A** - Amend Price List to add L10 and CALL10 modifiers:

25.55A Penetrating keratoplasty

AGE L10 Increase Base To 130%
CALL CALL10
1 For Each Call Pay Base At 100%
2-2 For Each Call Pay Base At 75%

■ **26.2 B** – Amend Price List to add L10 modifier

26.2 B Glaucoma implant procedures with reservoir shunts

AGE L10 Increase Base To 130%

Amended Health Service Codes (con't)

■ **26.25B** - Amend Price List to add L10 and CALL10 modifiers:

26.25B Trabeculectomy or major revision of trabeculectomy

AGE L10 Increase Base To 130%
CALL CALL10
1 For Each Call Pay Base At 100%
2-2 For Each Call Pay Base At 75%

■ **26.34A** – Amend description as follows:

26.34A Argon laser **trabeculoplasty**, selective laser **trubeculoplasty**, iridoplasty, goniopuncture

■ **26.71** - Amend Price List to add L10 and CALL10 modifiers:

26.71 Suture of complicated (traumatic) laceration of sclera with or without laceration to cornea

AGE L10 Increase Base To 130%
CALL CALL10
1 For Each Call Pay Base At 100%
2-2 For Each Call Pay Base At 75%

■ **27.72A -** Amend Price List to add BMI, L10 and CALL10 modifiers:

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

BMI BMIPRO Y Increase By 25%
AGE L10 Increase Base To 130%
CALL CALL10
1 For Each Call Pay Base At 100%
2-2 For Each Call Pay Base At 75%

■ **28.72B** – Amend Price List to add BMI and AGE modifiers:

28.72B Posterior total vitrectomy with 2 or 3 port infusion and cutting device

BMI BMIPRO Y Increase By 25%
AGE L10 Increase Base To 130%

■ **28.79B** – Amend Price List to add AGE and CALL modifiers:

28.79B Intravitreal injection for drug delivery

AGE L1 Increase Base To 200%
AGE L10 Increase Base To 130%
CALL CALL01
1 For Each Call Pay Base At 200%
2-2 For Each Call Increase By 167.97
CALL CALL10
1 For Each Call Pay Base At 100%
2-2 For Each Call Pay Base At 75%

Amended Health Service Codes (con't)

■ **29.02A** – Amend description to read as follows and add L10 modifier to the Price List

29.02A **Complicated orbital reconstruction or tumor excision**- first 90 minutes

AGE L10 For Each Call Pay Base At 130%
CALL CALL10
1 For Each Call Pay Base At 100%
2-2 For Each Call Pay Base At 75%

■ **43.0 A** – Amend description to read as follows:

43.0 A **Laryngeal injection of material excluding Botulinum A Toxin**

■ **50.24B** – Amend description to read as follows:

50.24B Correction of aortic vascular ring
Includes ligation of **patent ductus arteriosus (PDA)**

■ **50.94D –** Amend Price List to add L13 modifier:

50.94D Introduction of central venous catheter, with or without ultrasound guidance

AGE L13 Y Increase Base To 130%

■ **50.94E** – Amend Price List to add L13 modifier:

50.94E Introduction of catheter into peripheral vein, requiring ultrasound guidance

AGE L13 Y Increase Base To 130%

■ **52.2** – Amend Note to read as follows:

52.2 Regional lymph node excision
That for TB etc
NOTE: May not be claimed in addition to HSC**s 55.8 B, 55.9 AA and** 63.69A.

■ **52.31A** – Amend the note to read as follows:

52.31A Limited neck dissection (suprahyoid)
NOTE: HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician **at the same encounter**.

■ **52.31B** – Amend notes to read as follows:

52.13B Modified neck dissection with preservation of either one or two of the non-lymphatic structures, (e.g., sternocleidomastoid muscle, jugular vein or spinal accessory nerve), unilateral including removal of all neck lymph nodes
NOTE: 1. May not be claimed with HSCs 50.72C **or** 95.14E.
2. HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician **at the same encounter**.

Amended Health Service Codes (con't)

■ **52.31C** – Amend notes to read as follows:

52.31C Functional or selective neck dissection with preservation of all non-lymphatic structures, (e.g., sternocleidomastoid muscle, jugular vein, spinal accessory nerve), unilateral, including removal of three or more nodal levels in the neck
NOTE: 1. May not be claimed with HSCs 50.72C **or** 95.14E.
2. HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician **at the same encounter**.

■ **52.31D** – Amend Note 2 to read as follows:

52.31D Extended neck dissection
Removal of all neck lymph nodes and some non-lymphatic structures other than spinal accessory nerve, sternocleidomastoid muscle, or jugular vein. These structures may include the scalene muscle, deep neck muscles, hypoglossal nerve, carotid artery extensive resection of skin, etc, all related to or required because of tumor invasion of those structures
NOTE: 2. HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician **at the same encounter**.

■ **53.53A** – Amend description and add note to read as follows:

53.53A **Spleen - r**upture with repair
NOTE: may not be claimed for incidental repair.

■ **54.6** – Amend note to read as follows (remove HSC 65.7 C from note):

54.6 Esophagomyotomy
NOTE: May not be claimed with 54.76A, 65.7B, 65.8B or 65.8C.

■ **55.8 B** – Amend notes to read as follows:

55.8 B Radical sub-total
NOTE: **1.** May be claimed in addition to HSC 66.83.
2. May not be claimed in addition to HSCs 52.2, 56.2, 57.7 and 66.3 A.

■ **55.9 AA** – Amend note to read as follows:

55.9 AA Total gastrectomy for malignancy
NOTE: May not be claimed with HSCs **52.2,** 52.43A, 55.9 A**, 56.2,** 57.7 **and 66.3 A**.

■ **56.2** – Amend note to read as follows:

56.2 Gastroenterostomy (without gastrectomy)
NOTE: May not be claimed with HSCs **55.8 B, 55.9 AA,** 64.3, 64.43A, 64.49A or 64.7.

■ **56.4 A** – Add note to read as follows:

56.4 A Gastrectomy revision with or without resection
NOTE: May not be claimed in addition to HSC 66.4 A.

Amended Health Service Codes (con't)

■ **56.93D –** Amend note to read as follows:
56.93D Removal of gastric band
NOTE: May not be claimed in addition to HSC**s 56.93E, 66.4 A and** 66.83.

■ **56.93E** – Add note to read as follows:
56.93E Port revision or replacement
NOTE: May not be claimed in addition to HSC 56.93D.

■ **57.42A** – Amend Note 3 to read as follows:
57.42A Small bowel resection
NOTE: 3. May not be claimed in addition to HSC**s 57.7 or** 63.12B.

■ **57.7** – Amend Note 2 to read as follows:
57.7 Small to small intestinal anastomosis
NOTE: 2. May not be claimed in addition to HSCs **55.8 B, 55.9 AA,** 57.42A or 63.69A.

■ **62.12C** – Amend Note 2 to read as follows:
62.12C Partial resection of liver
NOTE: 2. May not be claimed in addition to HSC**s** 62.2 B, 63.12B or 63.69A.

■ **65.61A** – Add Note 4 to read as follows:
65.61A Repair of incisional hernia including mesh, if used
NOTE: **4. HSC 66.4 A may not be claimed in addition.**

■ **66.3 A** – Amend note to read as follows:
66.3 A Omentectomy, for abdominal malignancy, additional benefit
NOTE: May be claimed in addition to the primary procedure

■ **66.4 A** – Amend Note 3 to read as follows:
66.4 A Lysis of adhesions
NOTE: 3. May not be claimed in addition to HSCs 58.42A, 58.44A, 58.81A, 58.81B, 58.81C**, 65.61A** and 81.29C.

■ **66.83** - Add Note 3 to read as follows:
66.83 Laparoscopy
Diagnostic, with or without biopsy
NOTE: **3. May not be claimed in addition to HSC 56.93D.**

■ **91.01M** – Remove the UNDP (Undisplaced) modifier from Price List

HSC 91.01K should be claimed for an undisplaced fracture.

■ **92.78C** – Amend notes to read as follows:
92.78C Contrast arthrogram, unspecified site
NOTE: **1.** May not be claimed in addition to HSCs 16.89B, 16.89C or 16.89D.
2. May be claimed in addition to HSC 95.94C.

Amended Health Service Codes (con't)

■ **93.91B** – Add Note 3 to read as follows:

93.91B Joint aspiration, injection, other joints

NOTE: **3. HSCs 93.91A and 93.91B may be claimed in addition to HSC 95.94C.**

■ **95.93** – Amend notes to read as follows:

95.93 Injection/aspiration of therapeutic substance into bursa
Subacromial

NOTE: **1.** A second call may only be claimed when the second bursa is either aspirated and/or injected.

2. May be claimed in addition to HSC 95.94C.

■ **95.96A** – Amend notes to read as follows:

95.96A Other bursae, tendon sheaths, ganglion of wrist or ankle, aspiration, injection

NOTE: **1.** A second call may only be claimed when a second bursa, tendon sheath or ganglion is either aspirated and/or injected.

2. May be claimed in addition to HSC 95.94C

■ **96.02A** – Amend description to read as follows:

96.02A Amputation and disarticulation of thumb**, distal to MP joint**

■ **97.43** – Amend description to read as follows:

97.43 Unilateral augmentation mammoplasty by implant or graft **prosthesis**
That for reconstruction

■ **97.95** – Amend description, add note to read as follows and add CALL modifier to Price List.

97.95 Insertion of breast tissue expanders **for breast reconstruction**

NOTE: Bilateral procedures may be claimed using 2 calls.

CALL NBRSER

1	**For Each Call Pay Base At**	**100%**
2-2	**For Each Call Pay Base At**	**75%**

■ **97.96** – Amend description, add note to read as follows and add CALL modifier to Price List.

97.96 Removal of breast tissue expander **for breast reconstruction**

NOTE: **1.** When removal is the only procedure performed and not part of another procedure.

2. Bilateral procedures may be claimed using 2 calls.

CALL NBRSER

1	**For Each Call Pay Base At**	**100%**
2-2	**For Each Call Pay Base At**	**75%**

■ **98.49G** – Amend description to read as follows:

98.49G Functional split thickness skin graft 64 **and to 100** total square cms

Amended Health Service Codes

■ **X 55** – Amend description and Note 2 to read as follows:

X 55 **Spine, o**ne area

NOTE: 2. May only be claimed in addition to HSCs 16.89B, 16.89C or 16.89D once per year**, per patient**.

■ **X 56** - Amend description and Note 2 to read as follows:

X 56 **Spine, o**ne area – with obliques

NOTE: 2. May only be claimed in addition to HSCs 16.89B, 16.89C or 16.89D once per year**, per patient**.

■ **X128** – Add Note 4 to read as follows:

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

NOTE: **4. Nurse Practitioners and physicians that are part of Cancer Control Alberta may refer for patients under 50 years of age who are at high risk of bone density loss. Text is required on both the referral and the claim to indicate the patient's risk.**

■ **X306A** – Amend Note 4 to read as follows:

X306A Complex Complete Echocardiogram

NOTE: 4. In the rare case where a specific view or Doppler signal is **u**navailable, the reason shall be documented in the patient's record.

■ **X307** – Amend note to read as follows:

X307 Ultrasound, heart, Echocardiogram, limited

NOTE: May not be claimed in addition to HSC**s** X306A or X306B.

■ **X321** – Amend description to read as follows:

X321 Ultrasound, obstetrical, second or third trimester, **high risk –** for example, significant maternal disease (i.e. diabetes), fetal anomaly, fetal markers, Intrauterine Growth Retardation (IUGR), oligohydramnios, growth discordance in twins, suspected fetal anemia, genetics, fetal therapy

■ **X323 –** Amend Note 1 to read as follows:

X323 Ultrasound, heart (Echocardiogram), fetal, complete study

NOTE: 1. May not be claimed in addition to HSC**s** X306A, X306B and X337.

Amended Health Service Codes

- The following Health Service Codes are amended to change from ANE/ANEST to 2ANE/2ANES:

16.43D	16.43E	20.73	44.01	44.3 A	44.4 C	44.5 B
44.5 C	46.09B	46.1 A	46.1 B	46.3 B	46.3 C	47.02C
47.12A	47.12B	47.13A	47.13B	47.14A	47.14B	47.15A
47.15B	47.15C	47.25B	47.25C	47.25D	47.25E	47.39A
47.54A	47.55A	47.55B	47.55C	47.72A	47.72B	47.72C
47.81	47.82	47.83B	47.84A	47.91A	47.92A	47.92B
47.92C	47.93A	47.93B	48.0 A	49.62B	49.7 A	49.85
50.08A	50.08AA	50.09A	50.34B	50.34C	50.34K	50.34LA
50.75B	51.1 A	51.21A	51.21B	65.8 A	65.8 B	90.40B
91.15A	91.15B	93.69A				

Deleted Health Service Codes (and their replacement if applicable)

- **01.12 – see new HSC 01.12B**
- **17.08G**
- **20.55C**
- **32.5 A**
- **32.71A**
- **32.79A**
- **32.79E**
- **50.94F**
- **52.49E**
- **54.21A**
- **55.8 C**
- **55.8 D**
- **55.9 B**
- **55.9 C**
- **56.51A – see HSC 56.39A**
- **56.93 – see new HSC 56.93F**
- **65.01A – see new HSC 65.11A**
- **65.7 C – see new HSC 65.9 E**
- **65.8 C**
- **65.9 A – see HSC 58.81B or 58.81C**
- **67.01C**

Attachment C

New Modifier Definitions

■ CALL CALL01 – (Implicit) – This modifier allows payment of an additional
percentage for patients less than 1 year of age.

■ CALL CALL10 – (Implicit) – This modifier allows payment of an additional
percentage fo