To: all physicians and billing staff

The following changes have been made to the Schedule of Medical Benefits (SOMB):

1. Amendment to Health Service Code (HSC) X128;
2. Pre-operative physical examination for a cataract procedure;
3. Amendment to HSC 03.010.

Each of these changes is effective immediately, unless otherwise stated in the Bulletin. These changes will be reflected in the next version of the SOMB.

Amendment to HSC X128

Effective immediately physicians will be able to submit claims for HSC X128 when the referral is provided by a nurse practitioner or a physician that is part of Cancer Control Alberta for patients under 50 who are at high risk of bone density loss.

The amended HSC now reads as follows:

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

NOTE: 1. May only be claimed once every two years from the date of the last service.
2. For patients that are at high risk or have conditions that require more frequent assessments, text on both the referral and the claim for X128 describing the circumstances will be required.
3. May only be claimed for patients 50 years of age or older.
unless the patient is referred by a
Endocrinology/Metabolism, Gastroenterology, General
Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine
and Rehabilitation or Rheumatology specialist.

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 for X128 to indicate the patient’s risk.

This change will be reflected in the next version of the SOMB.

Pre-operative physical examination for a cataract procedure

Effective April 1, 2017, HSC 03.04M was amended to exclude it from being claimed when a pre-operative physical examination is requested for a cataract procedure (HSC 27.72A) that does not require the use of a general anesthetic.

Non-Hospital Surgical Facility (NHSF) Accreditation standards from the College of Physicians and Surgeons of Alberta (CPSA) indicate that a history and a physical must be completed on all surgical patients. This includes:
- Focused history
- List of medications
- Allergies
- And baseline vitals prior to the surgery

It is the responsibility of the physician performing the cataract procedure to complete the pre-operative assessment. The operating physician cannot refer the patient to a different physician for the completion of the pre-operative assessment. The operating physician may not submit claims for additional appointments in order to complete the pre-operative assessment prior to the cataract procedure.

Physicians who receive a request to complete a pre-operative assessment for a patient receiving a cataract procedure not under general anesthetic may not submit a claim using HSC 03.04M or any alternative health service code. In addition, the physician who received the request may not complete the pre-operative assessment and bill the patient.

Amendment to HSC 03.01O

Effective immediately physicians will be able to submit claims for e-consultations when the referral is provided by a nurse practitioner in independent practice.
The amended HSC now reads as follows:

03.010 Physician or Nurse Practitioner to Physician secure E-Consultation, consultant

NOTE: 1. May only be claimed when both the referring and consulting 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.
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 independent practice or working in a nursing station where no physician is present.

With the exception of the physical examination by the consultant, all e-consultations must meet the criteria outlined in GR 4.3 to 4.6.

This change will be reflected in the next version of the SOMB.