Hospital Reciprocal Claims Guide

Alberta

Ministry: Alberta Health

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The Hospital Reciprocal Claims Guide is intended solely as a reference tool for use by Hospitals, Community Ambulatory Care Centres and Urgent Care Centres in Alberta as a guide for submitting Hospital Reciprocal claims. It is not a legal document. In the event of conflict between information contained in this guide and any applicable legislation, including the *Alberta Health Care Insurance Act* and/or any Regulations thereunder, the applicable legislation will prevail.

Contents

Introduction

The purpose of this manual is to provide Alberta hospitals/health zones with a reference document outlining the policies, guidelines, and processes for interprovincial/territorial hospital claims for insured in-patient and outpatient hospital services.

The aim of the *Canada Health Act* is to ensure that all eligible residents of Canada have reasonable access to insured health services without charges related to their provision. Insured persons are eligible residents of a province/territory. A resident of a province/territory is defined in the *Act* as "a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province". Persons excluded under the *Act* include members of the Canadian Forces and inmates of federal penitentiaries.

In accordance with the interprovincial hospital reciprocal billing agreements, Alberta hospitals providing insured in-patient and outpatient services to eligible residents of other Canadian provinces/territories are entitled to payment of hospital costs. All provinces/territories participate in the hospital reciprocal billing process.

Under the reciprocal billing agreements, insured hospital in-patient services are payable at the hospital's standard ward or ICU per diem rate, as established by the host province/territory. This per diem rate is all-inclusive, with exceptions for specified high cost procedures. Outpatient insured services and specified in-patient procedures are payable in accordance with the rates established by the Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC).

As required, Alberta Health Services (AHS) will be notified through correspondence from Alberta Health regarding changes/updates to the following items:

- Hospital reciprocal billing agreements
- Service codes
- Outpatient rates
- In-patient rates
- High cost procedure rates
- Billing rules
- Hospital Reciprocal Claims Guide

Information on reciprocal billing for physician claims is not included in this manual. For further information on how to reciprocally bill physicians' claims, please see the Physicians Resource Guide available on the Alberta Health website at https://www.alberta.ca/fees-health-professionals.aspx.

1.0 Eligibility Requirements for Benefits

In accordance with the portability provisions of the *Canada Health Act*, residents who are temporarily absent from their province/territory of residence must continue to be covered for insured health services during their absence. This allows individuals to travel or be absent from their province/territory of residence, within a prescribed duration, while retaining their health insurance coverage.

1.1 Out-of-province Patient Eligibility Requirements

Patients who are temporarily absent from their province/territory of residence **must provide a valid provincial/territorial health card** when accessing insured health care services. Where the province/territory includes an expiry date on the health card, the card must be valid on the date(s) that the services were provided (Appendix B – Health Cards).

If there are eligibility issues with a patient's health card, he/she should contact their provincial/territorial beneficiary registration office to resolve any beneficiary entitlement concerns. Refer to Appendix A – Contact Information of this manual for Provincial/Territorial Ministry of Health contact information.

Patients who cannot provide a valid health card are directly responsible for the cost of the hospital services provided.

Quoting a number or using the patient's information already on file without presenting a card is not acceptable. **Hospitals must see the patient's current card and information on each visit. Failure to do so will result in the claim being adjusted.**

If a patient presents an out-of-province personal health card but provides an Alberta address, the patient must be asked if they have recently moved to Alberta. If the patient has lived in Alberta longer than three months, the hospital registration/admitting department must verify the patient's coverage under the AHCIP through Netcare. Alberta Netcare is the name of our provincial Electronic Health Record System. For more information on Alberta Netcare see www.albertanetcare.ca.

1.2 Persons Excluded from Benefits under Reciprocal Billing

The *Canada Health Act* definition of "insured health services" excludes services to persons provided under any other Act of Parliament or under the workers' compensation legislation of a province/territory. As such, the reciprocal billing arrangement excludes persons who are members of the Canadian Forces and persons serving a term of imprisonment within a federal penitentiary. The Government of Canada provides coverage to these groups through separate federal programs.

2.0 Excluded Services

The reciprocal billing arrangement for in-patient and outpatient insured hospital services only applies to those services insured by all provincial/territorial health insurance plans. A number of health care services have been identified as uninsured by all or some provinces/territories and are therefore excluded from the interprovincial reciprocal billing agreements.

Claims for excluded services cannot be billed through the reciprocal billing arrangement. Costs for these hospital services are the patient's responsibility and should be billed directly to the patient by the hospital. Patients who pay for a service must be provided with an itemized statement, so they can submit a reimbursement claim to their home provinces/territories health plan or, if applicable, their secondary insurer.

If a service is not insured in the patient's home province/territory but is insured in Alberta, the patient or the service provider/hospital may seek prior approval for payment from the patient's home province/territory prior to the patient receiving an elective service. Otherwise, the cost of the service is the patient's responsibility.

For emergency services where the service is not insured in the patient's home province/territory but is insured in Alberta, and there is not enough time to seek prior approval from the patient's home province/territory, the service is always covered by the interprovincial reciprocal billing agreements.

2.1 Excluded In-Patient and Outpatient Hospital Services

Health services excluded from hospital reciprocal billing are:

- Surgery for alteration of appearance (cosmetic surgery)
- Surgery for reversal of sterilization
- In-vitro fertilization, artificial insemination
- Lithotripsy for gall bladder stones
- The treatment of port wine stains other than on the face or neck, regardless of the modality of treatment
- Gamma Knife Radiosurgery
- Virtual Health/Telemedicine
- Gender reassignment surgery/Gender confirming surgery
- Dental services (except medically necessary oral surgery performed in a hospital) when provided by a dentist.

  Note: A dental service provided by a physician is not considered to be an excluded service.
- Acupuncture, acupressure, transcutaneous electro nerve stimulation, (TENS), moxibustion, biofeedback, hypnotherapy.
- PET scans (Except for selected medical indications. See Appendix E – PET-CT Scan Approved Clinical Indicators).
- Genetic screening and other genetic investigation, including DNA probes.
- Magnetoencephalography (MEG) Scan
- Islet cell transplants
- CAR-T cell therapy
- Brachytherapy
- Sleep labs

Albertans can access Gamma Knife Radiosurgery at the University of Alberta Hospital.

A prior-approval process outside the reciprocal agreements is in place for out-of-province patients referred to Alberta for Gamma Knife Radiosurgery.

2.2 Excluded Physician Services

Physician services, anesthetic services and surgical assistant services associated with services listed in Section 2.1 – Excluded In-Patient and Outpatient Hospital Services are excluded from Reciprocal Billing.

Routine periodic health examinations (i.e., physicals) and eye exams for the purpose of assessing how well an individual can see and whether that individual would benefit from refractive error correcting devices or surgery are also excluded when provided in a doctor's office.

2.3 Other Excluded Services

Other services excluded from reciprocal billing are:

- Prescription drugs administered outside the hospital setting
- Home care
- Charges for hostel care
- Services to persons covered by other agencies (e.g., Canadian Armed Forces, Workers' Compensation Boards, Department of Veterans Affairs, Correctional Services Canada (Federal Penitentiaries))
- Services requested by a third party
- Team conference(s)

2.4 Excluded Ambulance Services

Air and road ambulance services provided to out-of-province residents are not considered insured health care services by most provincial/territorial health insurance plans. As such, ambulance services are not covered under the reciprocal billing arrangement.

Canadians travelling out-of-province are responsible for ambulance costs, within and to/from other provinces/territories.

Residents should contact their provincial/territorial Ministry of Health for information about coverage for out-of-province ambulance services before leaving their province/territory of residence.

> The only exception is if the out-of-province patient is transferred by ground ambulance from one hospital to another for diagnostic and therapeutic services and the patient returns to the first hospital within 24 hours, the cost of the transfer is included in the standard ward rate of the first hospital. Please refer to item #5 in Section 5.6 – Standard Ward/Intensive Care Unit Per Diem Rates.

3.0 Claims Submission

Hospital reciprocal claims can be submitted to Alberta Health via H-link or can be mailed to:

Hospital Reciprocal Billing Unit
Alberta Health
PO Box 1360 Stn
Main Edmonton
AB T5J 2N3

Fax: 780-422-1958

Claim details are submitted on the following forms:

- Hospital Reciprocal Outpatient Services (AHC0216B)
- Hospital Reciprocal In-Patient Services (AHC0471)

The applicable summary statement must accompany a completed claim form:

- Summary Statement Hospital Outpatient Charges (AHC0562)
- Summary Statement Hospital In-Patient Charges (AHC0483)

3.1 Obtaining Alberta Health Forms

In-patient and outpatient claim forms, summary statement forms and hospital insurance coverage declaration forms can be found at the following website:

www.alberta.ca/health-professional-business-forms.aspx

Hospitals/health zones can choose to use their own computer-generated claim forms and summary statement forms, but first they must be reviewed and approved by Alberta Health to ensure they meet format requirements.

3.2 Time Limit Guidelines

The Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC) policy for submitting reciprocal hospital billing claims states that the Host Jurisdiction must submit eligible reciprocal billing claims within 12 months of the date of discharge for in-patient services or within 12 months from the service date for outpatient services.

To allow Alberta Health sufficient time to assess claims within this 12-month period, Alberta hospitals must submit claims to Alberta Health within ten months after the patient's date of service for outpatient claims and date of discharge for in-patient claims.

To submit a claim that is more than 10 months after the date of service/date of discharge, the hospital must wait until the claim is older than 12 months and obtain written approval from the out-of-province patient's home health plan in order for Alberta Health to be able to bill the patient's home province/territory (See Appendix A – Contact Information).

The request for approval must include:

- patient's name,
- date of birth,
- health care number,
- date of service for outpatient claims or date of admission and discharge for in-patient claims,
- hospital name, and
- reason for the delay in submitting the claim.

When received, the written approval must be sent to Alberta Health as an attachment with the claim submission. If the claim is submitted electronically the written approval must be faxed to Alberta Health.

After a WCB denial letter is received, hospitals have 12 months from the date of the WCB denial letter to submit a claim/adjustment. If the claim/adjustment is not submitted within 12 months of the date of the denial letter, the hospital must absorb the cost and cannot charge the patient. The WCB denial letter must be provided to the patient's province/territory of residence with the claim/adjustment.

If authorization of a reciprocal claim older than 12 months is rejected due to inadequate information collection by the hospital seeking reimbursement or written permission to submit an outdated claim has not been obtained, the hospital is not entitled to bill the insured patient directly or to refer the account to a collection agency. These claims must be written off and absorbed within the global budget.

3.3 Hospital Responsibilities for Submitting Reciprocal Claims

The out-of-province patient must present their valid health card in order to receive hospital services eligible under the reciprocal billing arrangement.

The hospital registration/admitting department is responsible for recording the following patient identification details:

- Patient's health card number
- Patient's surname and first name
- Patient's out-of-province address associated with patient's health card, including postal code
- Date of birth
- Gender
- Residency status
- Home province/territory
- Health card expiry date, if applicable

If the address is not available, the hospital needs written permission from the patient's home province/territory to bill c/o (care of) that province/territory's Ministry of Health. This is applicable to in patients only. Written permission should be sent to Alberta Health along with the claim.

Accuracy of this information is essential for Alberta Health to assess claims, pay Alberta Health Services and then invoice the patient's home province/territory for payment recovery. Incomplete or missing information will result in an adjustment and a loss of revenue for the hospital.

If a patient presents an out-of-province personal health card but provides an Alberta address, the hospital registration/admitting department must confirm that the patient does not have coverage under the AHCIP as well. (Refer to Section 1.1 – Out-of-province Patient Eligibility Requirements). Confirmation of the patient's eligibility is needed prior to submitting a claim.

3.4 Submitting Notes/Documents with Claims

The Alberta Health processing system will not recognize notes written directly on claim forms. Special notes/comments must be on a separate paper attached to the summary statement form that accompanies the claim form(s). Approval letters should also be attached to the summary statement form.

4.0 Outpatient Hospital Claims

4.1 Outpatient Definition

An out-patient is an individual who has been officially accepted by a hospital and receives one or more health services without being admitted as an in-patient, whose personally identifiable data is recorded in the registration or information system of the organization and to whom a unique identifier is assigned to record and track services.

4.2 Outpatient Services – Submitting Claims

Claims for outpatient services are submitted on the Hospital Reciprocal Outpatient Services form (AHC0216B). Completed outpatient claim forms must be accompanied by the Summary Statement Hospital Outpatient Charges form (AHC0562).

If a patient does not present a valid health card at the time of service, the service is not eligible for reciprocal billing, and the cost of the service is the responsibility of the patient. (Section 1.1 - Out-of-province Patient Eligibility Requirements).

The hospital is responsible for completing the Summary Statement Hospital Outpatient Charges form (AH0562) that includes certain mandatory data elements and confirms that the out-of-province patient's health card has been examined and that their address associated with their health card has been recorded in the hospital records.

Information on the summary statement form can be reported for only one hospital and one province/territory per form.

Outpatient claims may be submitted for services provided to eligible out-of-province patients in publicly funded and operated Community Ambulatory Care Centres in Alberta. A list of the Community Ambulatory Care Centres that may charge outpatient fees has been provided to Alberta Health Services and is updated as necessary.

4.3 Outpatient Services – Billing Rules

Claim submission deadline

- Claims must be submitted to Alberta Health within 10 months from the date of service. (Section 3.2 – Time Limit Guidelines)

Card expiry date requirement

- The patient's health card expiry date is required on all hospital reciprocal claims for patients from provinces/territories that display this information on their card. (Appendix B – Health Cards)
- Exception: Claims for Service Code 55 and 65 do not require the health card expiry date.

Cost of supplies

- The rates listed for outpatient services include the cost of supplies normally used in any procedure, but do not include supplies for use by patients after leaving the hospital.
- Appliances, splints, crutches, and canes are excluded from the outpatient rates. These items are the responsibility of the patient and should be charged to the patient.

Multiple outpatient services provided on the same day

- When two or more outpatient activities (service codes 51 to 62, 65 to 71) are provided to the same patient on the same day at the same hospital, only one outpatient service can be billed by the hospital (i.e., the one service with the highest rate).
- When service codes 51 or 68 to 70 are provided in addition to service code 63 to the same patient, at the same hospital, on the same date of service, the hospital can bill for both services. (i.e. code 69 and code 63).
- If you are billing an outpatient visit that occurred just before midnight (patient did not leave hospital) and the patient required a diagnostic procedure (e.g., a CT scan) during the same visit, only the greater is payable. In this example, the CT scan is payable but not the outpatient visit.

Transfers from one hospital to another hospital

- If a patient receives an outpatient service from one hospital and is transferred to another hospital for admission, the hospital providing the outpatient service can bill for this service. The hospital providing the in-patient services may bill at its standard ward or ICU rate, as applicable.

Same day in-patient/outpatient admissions

- An outpatient charge can be billed on the same day as an in-patient admission or discharge from the same hospital, as long as the patient is not a registered in-patient at the hospital at the time of service. This includes outpatient service codes 51 to 71.

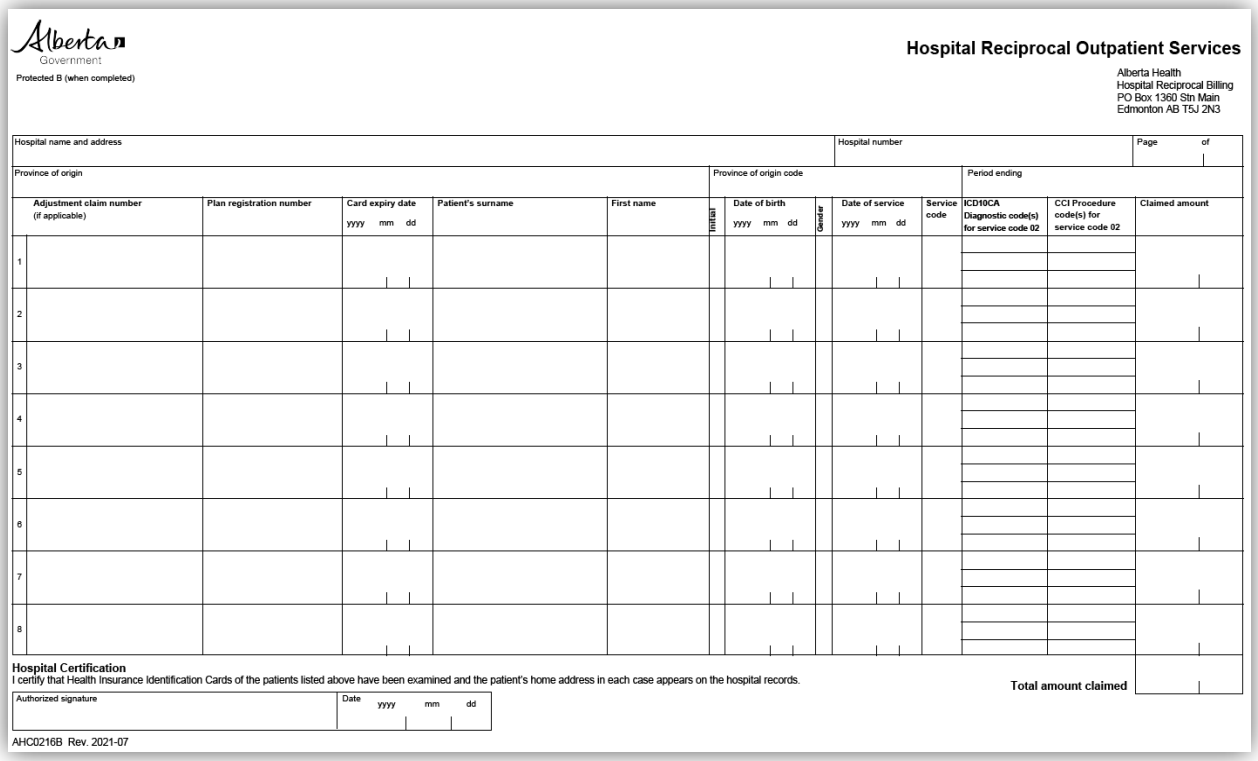
Outpatient services received while admitted as an in-patient

- Outpatient services provided prior to admission, or after discharge, may be billed in accordance with Rule 6.
- If a patient receives outpatient services while admitted as an in-patient, the hospital cannot bill for the outpatient services. In these instances, the cost of the outpatient services are included in the in-patient per diem rates.
- If a patient is admitted as an in-patient in Hospital A and is transferred to Hospital B to be treated for outpatient services that are unavailable in Hospital A, subsequently, is transferred back to Hospital A and remained registered as an inpatient; Hospital B is allowed to bill for the outpatient services.

Outpatient leaves before being seen

- If a patient is registered at a hospital as an outpatient and leaves before being seen by a physician or receiving treatment, code 51 may be billed.

Hospital Reciprocal Outpatient Services Claim Form (AHC0216B) – Sample



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Hospital Reciprocal Outpatient Services

Alberta Health
Hospital Reciprocal Billing
PO Box 1360 Stn Main
Edmonton AB T5J 2N3

Hospital name and address	Hospital number	Page of

Province of origin	Province of origin code	Period ending

	Adjustment claim number (if applicable)	Plan registration number	Card expiry date yyyy mm dd	Patient's surname	First name	Initial	Date of birth yyyy mm dd	Gender	Date of service yyyy mm dd	Service code	ICD10CA Diagnostic code(s) for service code 02	CCI Procedure code(s) for service code 02	Claimed amount
1													
2													
3													
4													
5													
6													
7													
8													

Hospital Certification
I certify that Health Insurance Identification Cards of the patients listed above have been examined and the patient's home address in each case appears on the hospital records.

Total amount claimed

Authorized signature	Date yyyy mm dd

AHC0216B Rev. 2021-07

4.4 Hospital Reciprocal Outpatient Services Claim Form (AHC 0216B) – Field Descriptions

Adjustment claim number

- This field is completed **only** when the hospital requests a previously paid claim to be adjusted. Enter the claim number under which the claim was previously paid. (Section 8.2 – Resubmitting an Applied (APLY) Claim).

Plan registration number

- The patient's out-of-province health care number.

Card expiry date – Field is entered as yyyy/mm/dd.

- Exceptions – For provinces/territories that display only a year and month on the health card, enter yyyy/mm.
- For provinces/territories that do not display an expiry date, leave this field blank. (Appendix B – Health Cards).

Patient's surname

- As it appears on the out-of-province health card. Do not enter dashes, periods or other special characters.

First name

- As it appears on the out-of-province health card. Middle name is not required.

Initial

- As it appears on the out-of-province health card. Leave blank if not applicable.

Date of birth

- As it appears on the out-of-province health card.

Gender

- F for female or M for male.

Date of service

- The date on which the service was provided.

Service code

- The code for the service provided. (Section 4.6 – Outpatient Services Codes and Rates).

ICD10CA diagnostic code(s) for service codes 68 to 71

- Diagnostic code (ICD-10 code) is no longer required on a claim when billing for day care surgery 68 to 70.
- For updated versions of the codes, call Canadian Institute of Health Information (CIHI) at 416-549-5402 or e-mail media@cihi.ca.

CCI procedure code(s) for service codes 68 to 71

- Enter at least one CCI (Canadian Classification of Health Interventions) code to identify the service provided when claiming service code 68 to 71.
- Up to three codes can be entered.
- There is a 10-character limit on this field. **Do not use special characters or decimals**.
- Leave this field blank if the claim is not for service code 68 to 71.
- Please consult the CCI code lookup table to determine how to bill for CCI code mapped to day care surgery low, medium, or high cost for claims submission. (**Note**: Alberta Health shares the table with AHS to assist hospital billing clerks and staff with hospital reciprocal billing only).
- For updated versions of the codes, call Canadian Institute of Health Information (CIHI) at 416-549-5402 or e-mail media@cihi.ca.

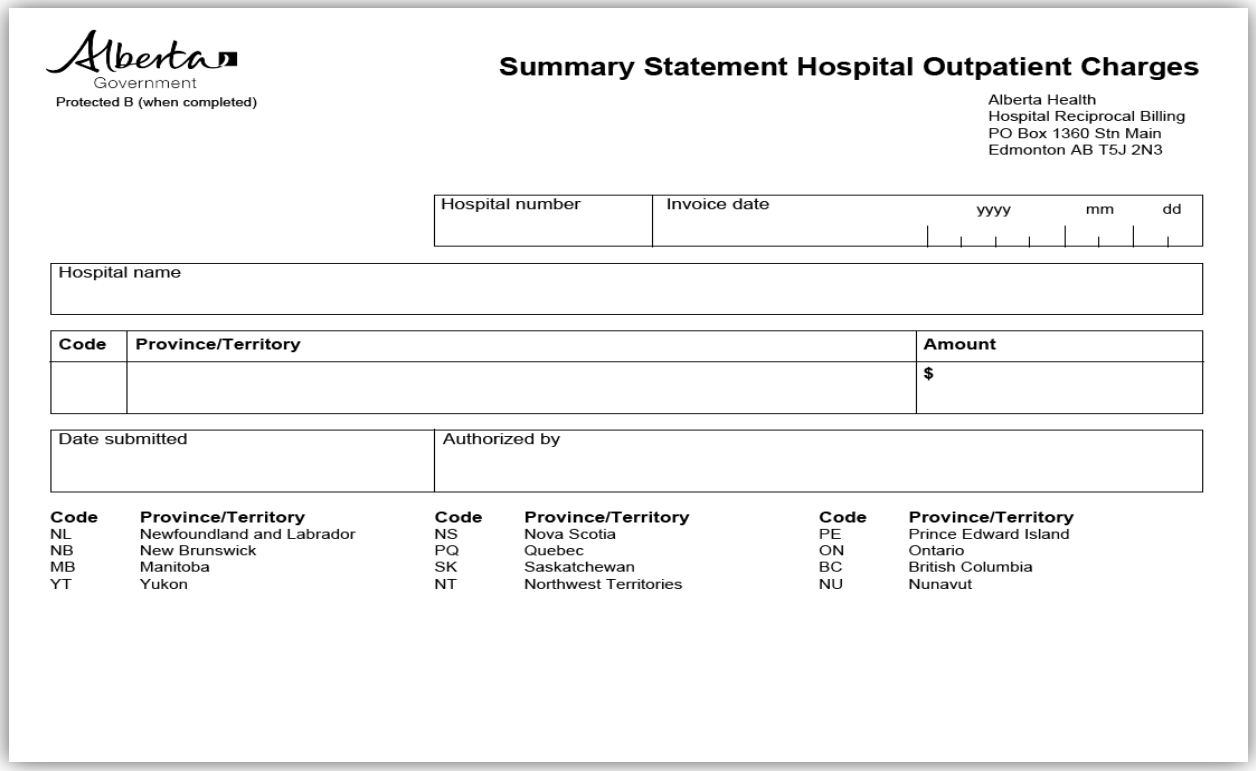
Claimed amount

- The amount for the service provided. (Section 4.6 – Outpatient Services Codes and Rates).

Total amount claimed

- The total for all services billed on the claim form.

4.5 Summary Statement Hospital Outpatient Charges (AHC0562) – Sample



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Summary Statement Hospital Outpatient Charges

Alberta Health
Hospital Reciprocal Billing
PO Box 1360 Stn Main
Edmonton AB T5J 2N3

Hospital number	Invoice date yyyy mm dd

Hospital name

Code	Province/Territory	Amount
		$

Date submitted	Authorized by

Code	Province/Territory	Code	Province/Territory	Code	Province/Territory
NL	Newfoundland and Labrador	NS	Nova Scotia	PE	Prince Edward Island
NB	New Brunswick	PQ	Quebec	ON	Ontario
MB	Manitoba	SK	Saskatchewan	BC	British Columbia
YT	Yukon	NT	Northwest Territories	NU	Nunavut

4.6 Outpatient Services Codes and Rates effective on or after April 1, 2024

Service Code	Description	Rate ($)
51	Standard Outpatient Visit, including select discrete high -cost diagnostic imaging procedures. Excludes specific services identified within other service codes. See Section 4.8, #1	440
52	Day Care Surgery single rate code retired. See codes 68 to 70.	
53	Hemodialysis	591
54	Computerized Tomography (CT)	768
55	Outpatient Laboratory and all other Diagnostic Imaging procedures not specifically listed elsewhere in this schedule of service codes. Includes general radiography, mammography, outpatient laboratory, and referred-in laboratory specimens except for those identified as High Cost-Cost Outpatient Laboratory Service Code 65. See Section 4.8, #2	173
56	Chemotherapy drugs totaling less than $1,000: Bill a visit fee of $440 PLUS the actual acquisition cost of the drugs. No invoice is required. Use service code 66 for chemotherapy drug costs totaling $1,000 or more. See Section 4.8, #3	
57	Cyclosporine/Tacrolimus/AZT/Activase/Erythropoietin/Growth Hormone therapy visit: **$311 plus the actual drug costs**.	
58	Extracorporeal Shock Wave Lithotripsy (ESWL) - Lithotripsy for stones within the gallbladder are excluded.	1,841
61	Magnetic Resonance Imaging (MRI) per day, including Radiologist services	696
62	Radiotherapy Services	683
63	Cardiac pacemakers and/or defibrillators (any type)/cochlear implants/PCI with stents/endovascular coils: the invoiced price of the device (invoice required) in addition to the rate applicable to either the Standard Outpatient Visit or Day Care Surgery. In order to bill code 63 the device(s) must total $1,000 or more. See Section 4.8, #8	
65	High Cost Laboratory for laboratory services not specifically listed elsewhere in this schedule of service codes, and **above $173:** the rate provided in the host province's schedule of benefits for laboratory medicine applies; or in the absence of a scheduled rate, an amount that is negotiated between the provincial plans (Genetic screening is excluded).	
66	Chemotherapy drugs totaling $1,000 or greater: Bill a visit fee of $440 PLUS the actual acquisition cost of the drugs. Invoice is required. Prior approval must be obtained for drugs over $5,000. See Section 4.8, #10 and Section 4.10.	
67	PET-CT Scan. See Section 4.8, #11	1,666
68	Day Care Surgery – Low. See Section 4.8, #12	1,335
69	Day Care Surgery – Medium. See Section 4.8, #12	4,860
70	Day Care Surgery – High. See Section 4.8, #12	14,945
71	X-ray with Cardiac Catheterization	1,962

4.7 Outpatient Services Codes – Rules of Application

Service Code 51 (Standard Outpatient Visit, including select discrete high cost diagnostic imaging procedures)

- Excludes specific services identified within other service codes.
- Select discrete high cost diagnostic imaging procedures include the following:
  - Nuclear medicine - diagnostic images and treatment procedures using radiopharmaceuticals. Includes single photon emission computed tomography (SPECT). Excludes nuclear medicine scans superimposed on images from modalities such as CT or MRI (e.g., SPECT/CT) which have their own service codes.
  - Fluoroscopy – an imaging technique to obtain real-time moving images of a patient through a fluoroscope, developed from the capture of external ionizing radiation on a fluorescent screen.
  - Ultrasound - the production of a visual record of body tissues by means of high frequency sound waves.
  - Interventional/Angiography Studies - the use of radiant energy from x-ray equipment during interventional and angiography studies. These radiographic techniques use minimally invasive methods and imaging guidance to perform studies that replace conventional surgery such as diagnostic arteriography, renal and peripheral vascular interventions, biliary, venous access procedures, and embolization.

Service Code 55 (Outpatient Laboratory and all other Diagnostic Imaging not specifically listed elsewhere in the Outpatient Service Codes)

- Includes general radiography, mammography, outpatient laboratory, and referred-in laboratory specimens except for those identified as High cost Outpatient Laboratory (Service Code 65).
- General radiography refers to the use of radiant energy from x-ray equipment for general diagnostic purposes. Mammography involves taking an x-ray of breast tissue for screening and/or diagnostic purposes.
- See Section 4.8 – Billing for Laboratory Services

Service code 56 (Low-Cost Cancer Chemotherapy Services)

- The term “Chemotherapy” reflects all drugs used to treat cancer (i.e., Monoclonal antibodies, Tyrosine kinase inhibitors, Angiogenesis inhibitors, etc.).
- Clinical trial and experimental drugs are not payable.
- Bill code 56 for chemotherapy drugs when the total cost of drugs provided during a visit is less than $1,000.
- Claims submitted under Code 56 do not require an invoice.

Service code 57 (Cyclosporin/Tacrolimus/AZT/Activase/Erythropoietine/Growth Hormone therapy visit)

- The rate that applies is $311 plus the actual drug costs. For example, if the drug cost is $100, the full cost of $411 ($311 + $100) is claimed.

Service code 58 (Extracorporeal Shock Wave Lithotripsy – ESWL)

- Service code 58 has been redefined as “extra-corporeal shockwave lithotripsy” (ESWL) to reflect the more common use of a lithotripter machine over invasive surgery.
- Lithotripsy procedures other than ESWL will be billed under day care surgery.
- Lithotripsy for gallstones outside the gall bladder is an excluded service.

Service code 61 (Magnetic Resonance Imaging - MRI)

- The hospital can only bill one MRI per day, per patient.
- Service code 51 cannot be claimed in addition.

Service code 62 (Radiotherapy Services)

- The hospital cannot bill service code 51 on the same day as a radiotherapy service.

Service code 63 (Pacemaker/Defibrillators/Cochlear Implants)

- When performed on an outpatient basis, the invoice price for the device is claimed using service code 63. The invoice for the device must be submitted along with the claim.
- A claim for service code 51 or 68-70, whichever applies, may be billed separately in addition to the claim for code 63.
- See Appendix D – CCI Codes for High Cost Procedures for related CCI Codes.

Service code 65 (High Cost referred-in laboratory specimens)

- The hospital receiving the specimen bills at the rate listed for the service in Alberta's Schedule of Medical Benefits. If no rate is listed, the service is billed at a rate that is negotiated between the provincial/territorial plans.
- Service code 65 does not apply to **routine** lab work when the patient is not present. These services are to be submitted using service code 55.
- Genetic testing is **excluded** from hospital reciprocal processing and may **not** be billed under service code 65 or any other service code.
- See Section 4.8 – Billing for Laboratory Services
- Do not enter the out of province health card expiry date on claims for HSC 65.

Service code 66 (High Cost Cancer Chemotherapy Services)

- The term "Chemotherapy" reflects all drugs used to treat cancer (i.e. Monoclonal antibodies, Tyrosine kinase inhibitors, Angiogenesis inhibitors, etc.).
- Clinical trial and experimental drugs are not payable.
- Bill code 66 for chemotherapy drugs when the total cost of drugs provided during a visit is $1,000 or greater.
- Claims submitted with Code 66 must be accompanied by a hospital invoice that must identify the patient (name, health number, date of administration) and the name/actual acquisition cost of the drugs used in the visit.
- Prior approval **must be obtained** for chemotherapy drugs when the total cost of drugs provided during a visit is greater than $5,000. (Section 4.10 – Requesting Prior-Approval for Chemotherapy Services).
- The prior-approval request and invoice should not include the number of units (vials, tablets, dosage, etc.) so that per unit price cannot be determined.
- Hospitals should not provide treatment until prior approval has been obtained.
- In emergency situations, where prior approval cannot be obtained in a timely manner, chemotherapy drugs can be reciprocally billed without prior approval. The host province must notify the home province in writing and provide a rational as to why prior-approval could not be requested, an adjustment can be requested and no rational is required.

Service code 67 (PET-CT Scans)

- A PET-CT scan can be billed only for approved clinical indications (Appendix E – PET-CT Scan). PET- CT scans outside of the approved indicators must still follow the prior approval process.
- For a PET-CT scan intervention to have occurred for one of the listed clinical indications, two conditions must be met:
  - A CCI code in the 3.**.70.CJ series must be reported on the patient record and
- A diagnosis code that is represented in the column 'ICD-10-CA-Codes for Cancer Type' must be reported on the patient record.

- Example: A patient visit with an ICD-10 CA diagnosis code of C56.1 (Malignant neoplasm of ovary, bilateral) and a CCI intervention code of 3.RM.70.CJ (Diagnostic nuclear (imaging) study, uterus using PE tomography (PET) with CT hybrid technique, single machine) meets both conditions, and can be assigned a cancer type of 'Gynecological Cancer', based on our table.

Service code 68 to 70 (Day Care Surgery – Low, Medium, High)

- A day care surgery patient is one who has been pre-booked and registered to receive services from a functional centre that is equipped and staffed to provide day surgery (e.g. an operating room, an endoscopy suite, a cardiac catheterization lab).
- Codes 68, 69 and 70 (Low, Medium, High) must include the correct billing rate and the corresponding CCI code. Claims that are missing or provide an invalid CCI code are subject to IHIACC's adjustment process. (Section 8.0 – Resubmission and Adjustments).

4.8 Billing for Laboratory Services

Outpatient claims for lab services (Code 55 and Code 65) may be submitted for services provided to eligible out-of-province patients who are registered as an outpatient and receive lab services in publicly funded hospitals or Community Ambulatory Care Centres (CACC).

Outpatient claims for lab services (code 55 or code 65) may be submitted for specimens referred to a publicly funded hospital lab for laboratory tests, but where the patient is not present. For the referred-in laboratory specimen, this is a composite fee for all specimens in relation to one patient.

If lab services in addition to another outpatient activity are provided to the same patient on the same day at the same hospital only one outpatient service can be billed by the hospital (i.e.: the one service with the highest rate).

If lab services are provided to an eligible out of province patient at a hospital admitted as an outpatient and a specimen is referred to another hospital for further laboratory testing for the same patient, both facilities can bill an outpatient claim reciprocally for lab services provided (code 55 or 65), using their respective facility numbers.

If a lab service cannot be conducted at the current hospital, then the hospital cannot bill for a service event. If a patient drops off a lab specimen but is not registered by the hospital as outpatient, then the hospital cannot bill for outpatient service. (For an outpatient service to occur, a patient must be registered at the hospital for the Ministerial Order to be applicable).

Scenario: If Hospital A receives a specimen and sends the specimen to Hospital B but Hospital B is unable to perform the service and sends it to Hospital C where it can be performed. Both Hospital A and Hospital C can bill an outpatient claim but not Hospital B as no service was provided.

If a service is provided in the community (non-hospital), then the patient or their health insurance would be responsible for the costs of the collection and the lab (provided at an AHS hospital) where the sample was referred can also bill.

If a Lab is included as part of a hospital, then any referred in specimens are reciprocally billable. Please refer to the Ministerial Order for Standard Ward/ICU Per Diem Rate Changes on approved hospitals that may reciprocally bill.

Laboratory services provided to an eligible out-of-province patient who is not registered as an outpatient in a hospital or are provided at a private lab are not eligible for reciprocal billing under the hospital reciprocal agreements. However, specimen referred for further laboratory testing for the same patient, can be billed through the hospital reciprocal agreements by the hospital receiving them.

Do not enter the out-of-province expiry date on your claims for HSC 55 and 65 lab services.

HOW TO BILL FOR LABORATORY SERVICES:

Scenarios	Cost = or < $173	Cost > $173
A. Referred in specimen	Code 55	Code 65
B. Patient presents at lab with referral from outside the hospital	Code 55	Code 65
C. Patient seen at emergency/outpatient department and presents at lab on the same day	Code 51	Bill code 51 if the laboratory service cost $440 or less. Bill code 65 if the laboratory service cost more than $440. Only one service code can be billed.
D. Patient seen at emergency/outpatient department and presents at lab on a different day	Code 51 for emergency department visit and code 55 for lab	Code 51 for emergency department visit and code 65 for lab

Outpatient laboratory services provided to individuals who are not eligible for coverage under the Alberta Health Care Insurance Plan should be billed as follows:

Laboratory Services provided at a hospital or CACC:

- Laboratory services provided must be billed at the rates and follow the rules of application as set out in the Out-Patient Goods and Services Ministerial Order (M.O.).

Laboratory Services provided at facilities OTHER than a hospital or CACC:

- Laboratory services provided may be billed at rates determined by the service codes in the SOMB, Ministerial Order or another manner as determined by the service provider.

4.9 Billing for Cancer Chemotherapy Services

	Scenario 1		Scenario 2		Scenario 3	
STEP 1 - Determining service code, invoice and prior approval requirements						
Drugs provided to the patient:						
April 14, 2024	Drug A	14.22	Drug A	14.22	Drug A	14.22
April 14, 2024	Drug B	4,968.00	Drug B	4,968.00	Drug C	93.39
April 14, 2024	--	--	Drug C	93.39	Drug D	45.10
Total drug costs used to determine: what code to bill, if an invoice is required and if prior approval is required:		4,982.22		5,075.61		152.71
Billing code used (code 56 under $1,000 or code 66 if $1,000 or over)		66		66		56
Invoice required (total is $1,000 or more)		YES		YES		NO
Prior approval required (total is over $5,000)		NO		YES		NO
STEP 2 - Determining the amount to claim						
Visit Amount*		440.00		440.00		440.00
Total Cost Claimed		5,422.22		5,515.61		592.71

* This amount is always the same (equal to out-patient code 51).

4.10 Requesting Prior Approval for Cancer Chemotherapy Services

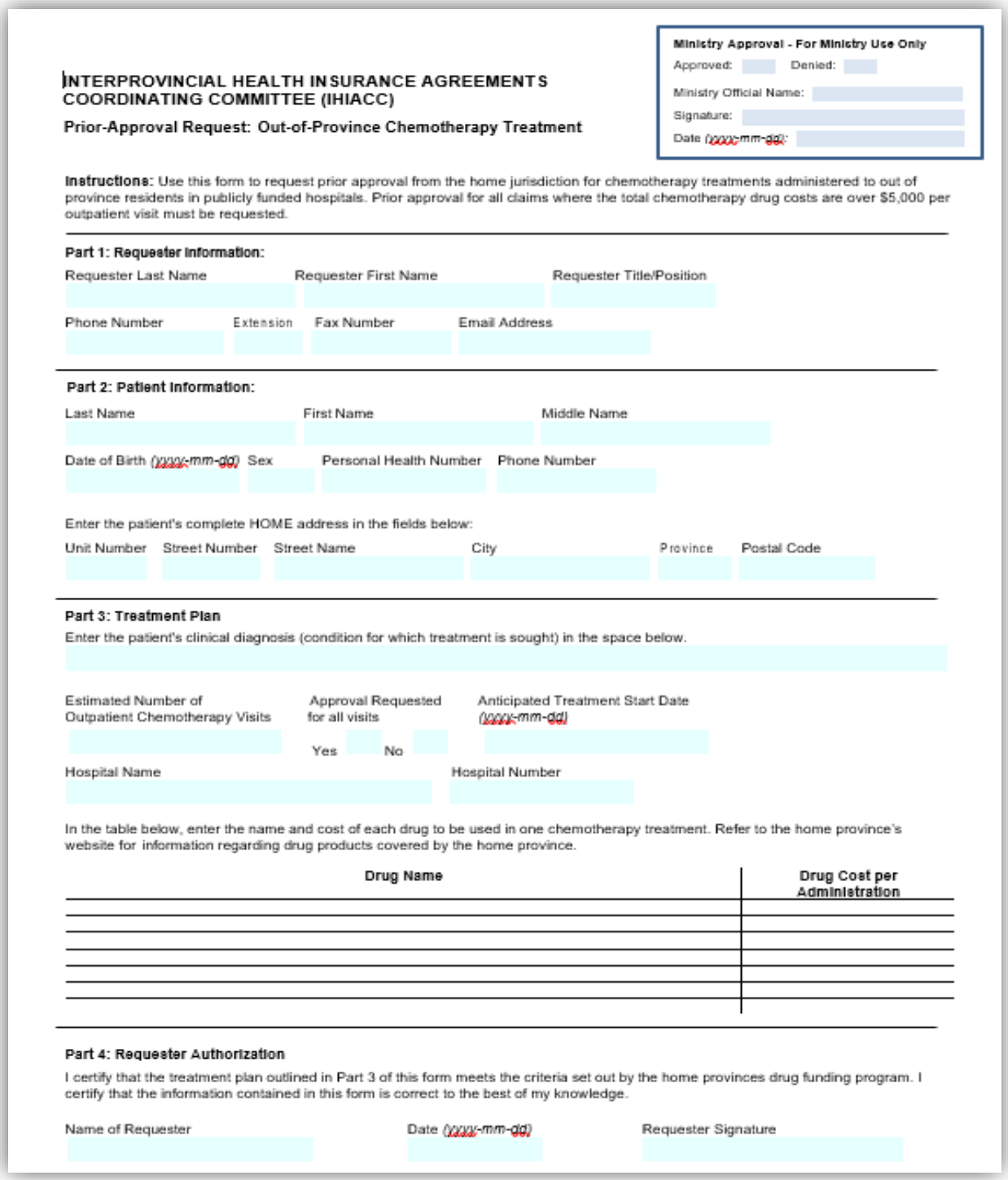
Prior approval must be obtained for chemotherapy drugs with a cost greater than $5,000. Hospitals should be informed that treatment should not take place until prior approval has been obtained. Hospitals must complete the IHIACC Prior- Approval Request: Out-of-Province Chemotherapy Treatment form to request prior approval from the Home Ministry. Hospitals should refer to the IHIACC Chemotherapy Prior-Approval Contact List for contact information from each jurisdiction on where to fax the form.

The IHIACC Prior-Approval Request: Out-of-Province Chemotherapy Treatment form is available on request by faxing the Hospital Reciprocal Billing Unit at 780-422-1958 or emailing a request to Health.HCIPAOOPOOC@gov.ab.ca.

Only one prior approval request is needed for patients that require multiple visits. Hospitals should indicate on the prior approval request form that repeat visits are required.

In emergency situations, where prior approval cannot be obtained in a timely manner, chemotherapy drugs can be reciprocally billed without prior approval. The host province must notify the home province in writing and provide a rationale as to why prior approval could not be requested; an adjustment can be requested if no rationale is provided.

4.11 IHIACC Prior Approval Request for OOP Chemotherapy Treatment Form - Sample



Ministry Approval - For Ministry Use Only
Approved: Denied:
Ministry Official Name:
Signature:
Date (yyyy-mm-dd):

INTERPROVINCIAL HEALTH INSURANCE AGREEMENTS COORDINATING COMMITTEE (IHIACC)

Prior-Approval Request: Out-of-Province Chemotherapy Treatment

Instructions: Use this form to request prior approval from the home jurisdiction for chemotherapy treatments administered to out of province residents in publicly funded hospitals. Prior approval for all claims where the total chemotherapy drug costs are over $5,000 per outpatient visit must be requested.

Part 1: Requester Information:

Requester Last Name | Requester First Name | Requester Title/Position

Phone Number | Extension | Fax Number | Email Address

Part 2: Patient Information:

Last Name | First Name | Middle Name

Date of Birth (yyyy-mm-dd) | Sex | Personal Health Number | Phone Number

Enter the patient's complete HOME address in the fields below:

Unit Number | Street Number | Street Name | City | Province | Postal Code

Part 3: Treatment Plan

Enter the patient's clinical diagnosis (condition for which treatment is sought) in the space below.

Estimated Number of Outpatient Chemotherapy Visits | Approval Requested for all visits: Yes / No | Anticipated Treatment Start Date (yyyy-mm-dd)

Hospital Name | Hospital Number

In the table below, enter the name and cost of each drug to be used in one chemotherapy treatment. Refer to the home province's website for information regarding drug products covered by the home province.

Drug Name	Drug Cost per Administration

Part 4: Requester Authorization

I certify that the treatment plan outlined in Part 3 of this form meets the criteria set out by the home provinces drug funding program. I certify that the information contained in this form is correct to the best of my knowledge.

Name of Requester | Date (yyyy-mm-dd) | Requester Signature

5.0 In-patient Hospital Claims

5.1 In-patient Services – Submitting Claims

The Hospital Reciprocal In-patient Services form (AHC0471) is used to submit claims for:

- In-patient stays (per diem ward rate). Depending on the hospital, separate rates may apply to standard ward beds and ICU beds within the same hospital.
- High cost procedures – Organ transplants and bone marrow/stem cell transplants and special implants/devices.

In-patient claim forms must be submitted to Alberta Health with covering Summary Statement Hospital In-Patient Charges forms (AHC0483).

See Section 5.3 - Hospital Reciprocal In-patient Services Claim Form (AHC0471) for a sample of the in-patient claim form and Section 5.13 - Summary Statement Hospital In-Patient Charges (AHC0483) for a sample of the summary statement form.

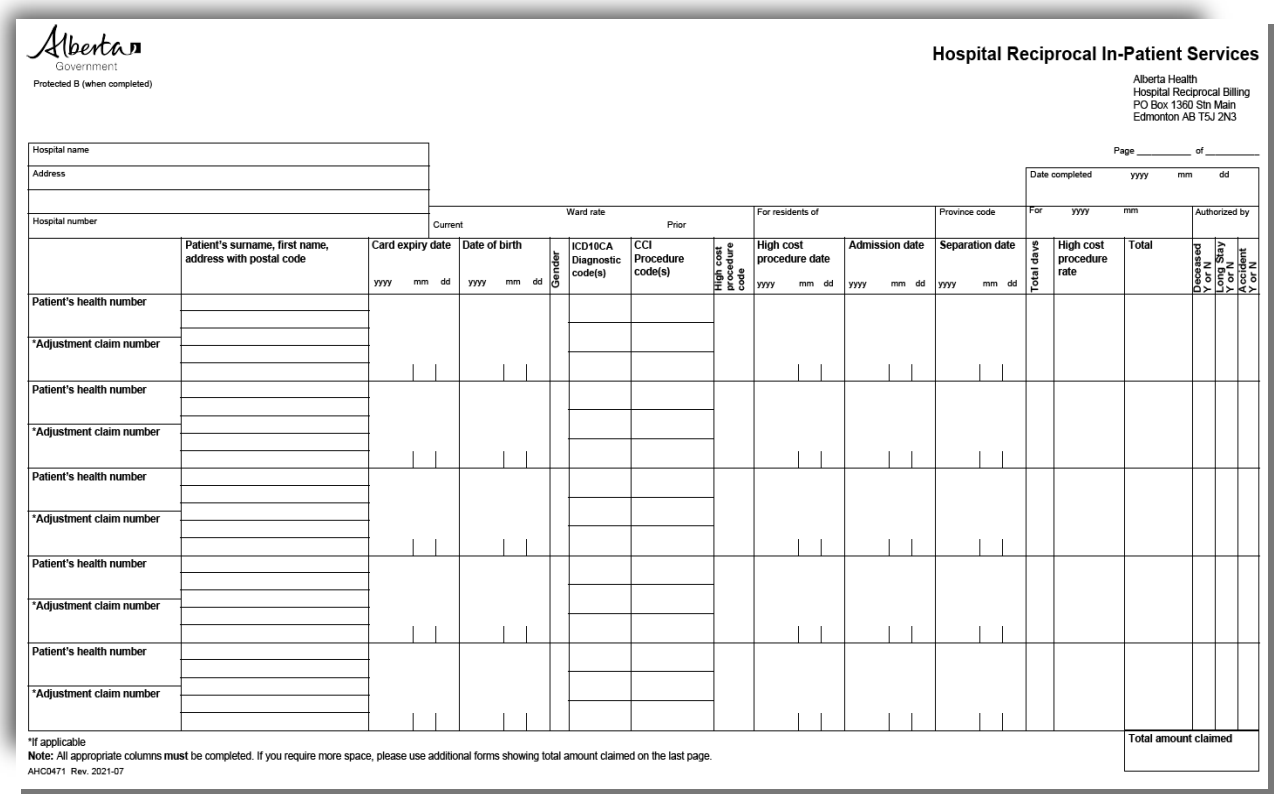
Claims with standard ward rates must be submitted on separate claim forms than claims with ICU rates from the same facility, as the hospital facility numbers for standard ward beds and ICU beds within the same facility are different.

Information on the summary statement form can be reported for only one hospital number and one province/territory per form. Therefore, standard ward and ICU claims will require separate summary statement forms.

5.2 In-Patient Services – Mental Health Facilities

Effective April 1, 2023, the Centennial Centre, Alberta Hospital Edmonton, Claresholm Centre, Villa Caritas and the Southern Alberta Forensic Psychiatry Centre can reciprocally bill in-patient per diem rates for the provision of emergency mental health services. Coverage and payment for all other non-emergent mental health services provided by mental health facilities is to be arranged outside reciprocal billing.

5.3 Hospital Reciprocal In-patient Services Claim Form (AHC0471) – Sample



Alberta Government

Protected B (when completed)

Hospital Reciprocal In-Patient Services

Alberta Health
Hospital Reciprocal Billing
PO Box 1360 Stn Main
Edmonton AB T5J 2N3

Page _____ of _____

Hospital name

Address

Hospital number

Date completed yyyy mm dd

Ward rate: Current / Prior

For residents of

Province code

For yyyy mm

Authorized by

	Patient's surname, first name, address with postal code	Card expiry date yyyy mm dd	Date of birth yyyy mm dd	Gender	ICD10CA Diagnostic code(s)	CCI Procedure code(s)	High cost procedure code	High cost procedure date yyyy mm dd	Admission date yyyy mm dd	Separation date yyyy mm dd	Total days	High cost procedure rate	Total	Deceased Y or N	Long Stay Y or N	Accident Y or N
Patient's health number																
*Adjustment claim number																
Patient's health number																
*Adjustment claim number																
Patient's health number																
*Adjustment claim number																
Patient's health number																
*Adjustment claim number																
Patient's health number																
*Adjustment claim number																

*If applicable

Note: All appropriate columns **must** be completed. If you require more space, please use additional forms showing total amount claimed on the last page.

AHC0471 Rev. 2021-07

Total amount claimed

5.4 Hospital Reciprocal In-patient Services Claim Form (AHC0471) – Field Descriptions

Ward rate

- This field has two areas: “Current” and “Prior”. **Only** the current ward rate is entered. The “Prior” area is **always** left blank (Section 5.5 – Hospital Reciprocal In-patient Services Claim Form (AHC0471) – Completing the Ward Rate Field).

Patient’s health number

- The patient’s out-of-province health care number.

Adjustment claim number

- This field is completed **only** when the hospital requests a previously paid claim to be adjusted. Enter the claim number under which the claim was previously paid (Section 8.2 – Resubmitting an applied (APLY) claim).

Patient’s surname, first name, address with postal code

- All elements in this field are mandatory. If not included, the claim will be refused.
  - Do not enter dashes, periods or other special characters.
  - Middle name is not required.
  - The address must be the **out-of-province address** associated with the patient’s health card.

If the patient has recently moved to Alberta but still has health coverage in their former province/territory of residence, enter their former out of province address, not their new Alberta address.

If the out of province address is not available, contact the former province/territory to request written approval to submit the claim with an address provided by the former province/territory. If approved, the approval letter must be sent with the claim. (Section 3.4 Submitting Notes/Documents with Claims, as well as Appendix A – Contact Information).

Card expiry date

- This field is entered as yyyy/mm/dd.
- Exceptions:
  - For provinces/territories that display only a year and month on their health card, enter yyyy/mm.
  - For provinces/territories that display the month as alpha characters on their health card (i.e. yyyy/mmm/dd), enter the month as a numeric value.
  - For provinces/territories that do not display an expiry date, leave this field blank. (Appendix B – Health Cards).

Date of birth

- As it appears on the out-of-province health card.

Gender

- F for female or M for male.

ICD10CA diagnostic code(s)

- All in-patient claims require **at least one** ICD10CA diagnostic code.
- Up to three codes can be entered.
- When applicable, **ensure the decimal is clearly entered** after three characters. No decimal is needed if only three characters are entered.

CCI procedure code(s)

- All claims for high cost procedures and all claims for a hospital stay during which another procedure was performed require at least one CCI (Canadian Classification of Health Intervention) code to identify the service provided.
- Up to three codes can be entered.
  Do not use special characters or decimals.

High cost procedure code

- This field is used when claiming service codes 101 to 323 and 600 to 607. (Section 6.0 – High Cost Procedures).

High cost procedure date

- If applicable, this field is used to identify the date on which a high cost procedure was performed.

Admission date

- The date on which the patient was admitted.

Separation date

- The date on which the patient was discharged.

> The admission date and separation date fields are completed only on claims for in-patient per diem days. Leave these fields blank on claims for high cost procedure service codes. (Section 6.0 – High Cost Procedures).

Total days

- The total number of days the patient was hospitalized, less the discharge day and, if applicable, the date of transplant.

High cost procedure rate

- Leave this field blank until further notice. The rate claimed for the high cost procedure is entered in the "Total" field.

Total

- This field has two purposes:
  - When claiming a high cost procedure, enter the high cost procedure rate.
  - When claiming per diem hospital days, enter the total amount for daily care – the daily ward rate multiplied by the number of days of hospitalization, not including the discharge day and, if applicable, the date of transplant.

Deceased, long stay, accident

- Y (yes) or N (no), as applicable. If left blank, the field will default to N and the claim will be processed accordingly.
- If long stay, hospital **must** bill Alberta Health monthly to allow for prompt invoicing to other provinces. For additional information, please see Section 5.6 – Standard Ward/Intensive Care Unit Per Diem Rates.

Total amount claimed

- The total for all services submitted on the claim form.

5.5 Hospital Reciprocal In-patient Services Claim Form (AHC0471) – Completing the Ward Rate Field

The ward rate field on the in-patient claim form has two areas: “Current” and “Prior”.

- Only the current ward rate is entered. “Current” means the ward rate in effect for the date(s) of service being claimed. For an exception, see Section 5.6 – Standard Ward/Intensive Care Unit Per Diem Rates, bullet #2, “In-patient stay spanning two fiscal years”.
- The “Prior” area is always left blank.
- The ward rate entered for each claim on the claim form **must be the approved rate at the date of discharge**.
- See the examples below (Section 5.6 – Standard Ward/Intensive Care Unit Per Diem Rates).

Example 1 – use two claim forms

Patient A – Healthy newborn	Patient B – Adult
Daily ward rate = $1,147.00	Daily ward rate = $1,400.00

In Example 1, the claims for patient A and patient B must be submitted on **separate claim forms** because the healthy newborn and adult ward rates are different.

Example 2 – use two claim forms

Patient C – Adult	Patient D – Adult
Admission date = March 24, 2024	Admission date = April 2, 2024
Separation date = March 30, 2024	Separation date = April 8, 2024
Daily ward rate = $1,135.00	Daily ward rate = $1,400.00

In Example 2, the claims for patient C and patient D must be submitted on **separate claim forms** because the ward rate was changed effective April 1, 2024.

5.6 Standard Ward/Intensive Care Unit Per Diem Rates

All claims for insured in-patient stays are billed at the applicable per diem rate specified for each Alberta hospital, as authorized by Alberta Health. When these rates are updated, Alberta Health provides the details in correspondence to Alberta Health Services.

In-patient standard ward and intensive care unit (ICU) services are billed using two different methods:

1. Using separate rates for ward and ICU (the split standard ward/ICU method); or
2. Using combined standard ward/ICU rate or a standard ward rate.

Standard Ward/ICU Billing Method

Hospitals that have implemented the split ward/ICU billing methodology are assigned two separate in-patient per diem rates: one for standard ward services and another for ICU services.

- Standard ward per diem rates exclude ICU costs and are billed for in-patient stays of a standard ward nature only.
- The ICU per diem rate is billed for in-patient days provided in ICU. Refer to Section 5.7 – Rules of Application – Standard Ward/Intensive Care Unit Per Diem Rates for methods on determining the number of patient days spent in ICU.

ICU beds carry a different facility number than the standard ward beds within the same hospital.

- Per diem claims for patients in the standard ward must be submitted with the **three-digit** facility number assigned to the hospital.
- Per diem claims for patients in the ICU must be submitted with the **four-digit** facility number assigned to the hospital.

Claims for standard ward per diem rates and ICU per diem rates from the same hospital must be submitted on separate claim forms. These separate claim forms also require separate Summary Statement forms, as the facility numbers are different.

Combined Rate or Standard Ward Rate Billing Method

Hospitals that have **not** implemented the in-patient split standard ward/ICU billing methodology but provide both standard ward and ICU services are assigned one combined per diem rate inclusive of standard ward and ICU costs. Hospitals that provide only standard ward services use the standard ward rate.

5.7 Rules of Application - Standard Ward/Intensive Care Unit Per Diem Rates

In-patient admission and discharge date

1. When submitting claims for standard ward, ICU or healthy newborn in-patient stays, the per diem hospital rate is multiplied by the number of days of hospitalization, less one day – the discharge date.

- If a patient is admitted and discharged on the same date, that date is considered as one in-patient day stay. This date is entered in both the admission date and separation date fields on the claim form.

2. In-patient claims when admission and discharge dates are consecutive and not interrupted.

- It is important that the in-patient claims be predetermined, prepared and submitted to AH **monthly** in a proper and orderly method so that the claims (claim lines) **are not broken up sporadically into numerous claims** with dates of service for only a few days and/or for each week. This applies to whether submitting in-patient claims with or without ICU and HCP's and especially for long term in- patient stays. If claims are not submitted monthly, they could be refused and/or not paid correctly. It also has an impact with the billings and reports. Refer to #4 long term in-patient stays.

Scenario: In-patient stay is from Jan 1 2024 – April 1 2024:

Using 3 claim lines
Jan 1 – Feb 1 2024 – submit to AH end of January
Feb 1 – March 1 2024 – submit to AH end of February
March 1 – April 1 2024 – submit to AH end of March

In-patient stay spanning two fiscal years

When an in-patient stay extends over two fiscal years and the authorized ward rate has changed during the period, the hospital must bill the portion of the stay occurring in each fiscal year at the respective year's ward rate. A fiscal year runs from April 1 to March 31.

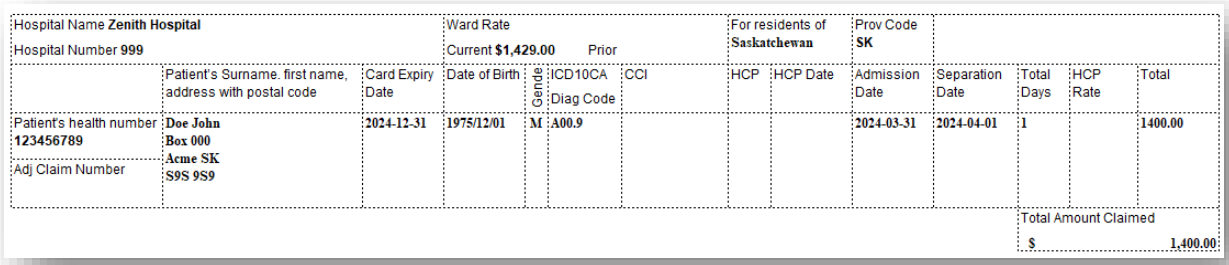
The scenarios described below will assist in calculating claim amounts when there is a rate change during a patient's stay. As two different rates are used, two different claim lines must be submitted. Bone marrow/stem cell transplant rates are block rates inclusive of any length of in-patient stay (Section 6.8 – Bone Marrow & Stem Cell Transplant – Service Codes & Rates). For these block rates, the date of discharge is used for billing purposes regardless of services being provided over two fiscal years.

The following scenarios demonstrate the billing concept:

Scenario 1: Ward/ICU rate change on the date of discharge

Admission date:	March 31, 2024
Discharge date:	April 1, 2024
Billable in-patient day(s):	1 in-patient day
Old ward rate:	April 1, 2023 to March 31, 2024 = $1,400.00
New ward rate:	April 1, 2024 = $1,429.00

- Enter all required claim submission data with admission date March 31, 2024 and separation date April 1, 2024.
- Enter $1,1429.00 in the “Current” area of the Ward Rate field.



Hospital Name **Zenith Hospital** Hospital Number **999**			Ward Rate Current **$1,429.00** Prior				For residents of **Saskatchewan**		Prov Code **SK**				
	Patient's Surname, first name, address with postal code	Card Expiry Date	Date of Birth	Gende	ICD10CA Diag Code	CCI	HCP	HCP Date	Admission Date	Separation Date	Total Days	HCP Rate	Total
Patient's health number **123456789** Adj Claim Number	**Doe John Box 000 Acme SK S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**A00.9**				**2024-03-31**	**2024-04-01**	**1**		**1400.00**
											Total Amount Claimed $ 1,400.00		

- Enter $1,429.00 in the Total field (old ward rate 1 day). The amount claimed is $1,400.00 because the discharge date is not billed.

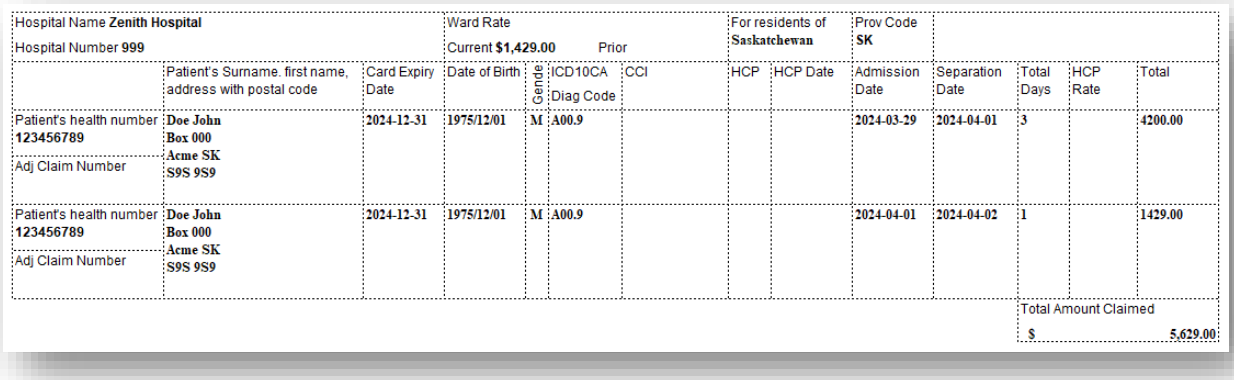
Scenario 2: Ward/ICU rate change during the in-patient stay

Admission date:	March 29, 2024
Discharge date:	April 2, 2024
Billable in-patient day(s):	4 in-patient days
Old ward rate:	April 1, 2023 to March 31, 2024 = $1,400.00
New ward rate:	April 1, 2024 = $1,429.00

- Enter $1,429.00 in the “Current” area of the Ward Rate field.
- Complete two claim lines:

Line 1: Enter all required data, with admission date March 29, 2024 and discharge date April 1, 2024.
Enter $4,200.00 in the Total field (old ward rate 3 days).

Line 2: Repeat the required data, but with admission date April 1, 2024 and discharge date April 2, 2024.
Enter $1,429.00 in the Total field (new ward rate 1 day).



Hospital Name **Zenith Hospital** Hospital Number **999**			Ward Rate Current **$1,429.00** Prior				For residents of **Saskatchewan**		Prov Code **SK**				
	Patient's Surname, first name, address with postal code	Card Expiry Date	Date of Birth	Gende	ICD10CA Diag Code	CCI	HCP	HCP Date	Admission Date	Separation Date	Total Days	HCP Rate	Total
Patient's health number **123456789** Adj Claim Number	**Doe John Box 000 Acme SK S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**A00.9**				**2024-03-29**	**2024-04-01**	**3**		**4200.00**
Patient's health number **123456789** Adj Claim Number	**Doe John Box 000 Acme SK S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**A00.9**				**2024-04-01**	**2024-04-02**	**1**		**1429.00**
											Total Amount Claimed $ 5,629.00		

Patient released on a pass

When an out-of-province/territory patient is released from the hospital on a temporary pass and the bed is being retained for that patient, the hospital can bill for the period during which the bed was retained, to a maximum of 72 hours (three in-patient days).

Long-term in-patient stays

Important: If a patient is still in the hospital at the end of the month, claims **must** be submitted monthly. Not following this rule has a financial impact with the billings and reports that Alberta Health's sends to the out of province health ministry. When claiming monthly, always use the first day **of the next month** as the discharge date. Do not use "SIH" (still in hospital) as the processing system does not recognize this term.

The billing policy above does not apply when billing bone marrow/stem cell transplant rates. These rates are inclusive of long-term hospital stays.

Hospitals providing services to an out-of-province patient must notify Alberta Health by the 30th day of a patient's in-patient stay if the patient requires a continuous in-patient stay of more than 30 days. Hospitals must provide updates on the patient's status every subsequent 30th day of a continuous in-patient stay (i.e., notification on day 30, day 60, day 90, etc.).

Transfers from one hospital to another hospital

- Out-of-province patient is admitted to one hospital, and then transferred to another hospital **on the same day**.
  a) Both hospitals can bill the applicable in-patient rate(s) for the date of transfer.

- Out-of-province patient receives an outpatient service from one hospital and is then transferred to another hospital for admission.
  - The hospital providing the outpatient service can bill the outpatient rate for that service.
  - The hospital providing the in-patient service can bill the applicable in-patient rate(s).
- Out-of-province patient is **transferred by ground ambulance** from one hospital to another hospital for diagnostic or therapeutic services and the patient returns to the first hospital within 24 hours.
  - The cost of the transfer is included in the per diem rate(s) of the first hospital.
  - The patient should not be billed for the ambulance service.
  - If patient is admitted to second hospital, the first hospital cannot bill for transfer date.

- Out-of-province patient is **transferred by means of transport other than ground ambulance** from one hospital to another hospital for diagnostic or therapeutic services and the patient returns to the first hospital within 24 hours.
  - The cost of the transfer is the patient's responsibility.

- Out-of-province patient receives in-patient services at one hospital and then **at a later date** is transferred to another hospital.
  - Both hospitals can bill the applicable in-patient rate(s); however, only the second hospital can bill for the date of transfer.
  - For example: Patient receives in-patient services in Hospital A from May 5th to 8th. On May 8th the patient is transferred to Hospital B and receives in-patient services until May 12th, only Hospital B can bill for May 8th.

Same day outpatient/in-patient admissions at the same hospital

A hospital can bill an outpatient rate (service codes 51-70) and an in-patient rate for the same day, as long as the patient is not a registered in-patient at the time the outpatient service is provided.

Rules of application:

- If a patient receives an outpatient service and is later admitted to the same hospital on an in-patient basis on the same day, the hospital can bill for both the outpatient service and the in-patient stay for that day (i.e., the admission date and the date of outpatient service are the same).
- If a patient is discharged from the hospital and is provided an outpatient service at the same hospital on the same day, the hospital can bill for the outpatient service (i.e., the discharge date and the date of the outpatient service are the same).

5.8 Intensive Care Unit Days – Calculation and Billing

There are **two methods** for calculating ICU days — billing by hours and minutes, or billing using the midnight rule (billing the ICU per diem rate for those days on which a patient is in ICU as of midnight that day).

If a patient is admitted and discharged from hospital within 24 hours, that time in hospital is considered as one in-patient day stay regardless of billing by hours and minutes or the midnight rule. However, to claim an ICU day for a hospital stay of less than 24 hours, the entire stay must be in ICU.

Billing by hours and minutes

1. Calculate total days of hospitalization (i.e., discharge date – admit date, less one)
2. Calculate the total number of ICU days by following the steps below:
   - Step 1: Calculate total ICU hours.
   - Step 2: Calculate the number of ICU days by dividing the total hours calculated in step 1 by 24 (i.e., total ICU hours/24).
   - Step 3: If the remainder of hours calculated in step 2 is greater than or equal to 12 hours, round up one day. If the remainder is less than 12 hours, round down.

This calculation applies to stays that include Ward and ICU together.

Example:

If total ICU hours = 100, then number of ICU days = 4.17 (100/24). The remainder (0.17) represents 4 hours, therefore total ICU days equals 4.

3. Calculate ward days (i.e., total days of hospitalization - ICU days = ward days)

4. **Note**: ICU starting date = admit date

Remaining ICU days, if any, are listed as if they occurred immediately after the admit date. For example, if the admit date was April 1 and there were four days in ICU, then report ICU days as April 1, 2, 3 and 4.

Example:

Patient is admitted September 1st and is discharged September 10th. Billing should be completed as follows:

ICU
Admit date: September 1, 2024
Discharge from ICU unit: September 5, 2024 Total
days billed: 4 days ICU

Ward
Admit date: September 5, 2024
Discharge from hospital: September 10, 2024 Total
days billed: 5 days

Billing clerks should determine appropriate billings for ICU and ward submissions based on the above rules; that is, one form for ICU and one form for Ward, using the appropriate facility number for each. The discharge date of the first unit would be the admit date of the second unit.

Billing using the midnight rule

To claim an ICU day using the midnight rule, a patient stay in ICU must span midnight.

Examples:

1) If a patient is in ICU from 4 p.m. April 1st to 10:30 p.m. April 2nd, the ICU per diem rate is billed for one day.

2) If a patient is in ICU from 4 p.m. April 1st to 8 p.m. April 1st then transferred to ward, no ICU per diem rate is billed.

3) If a patient is in ICU from 11 p.m. April 1st to 2 a.m. April 2nd, the ICU per diem rate is billed for one day.

5.9 Newborn Rates – Calculation and Billing

The table below provides guidance on how to bill for newborns based on their condition and the billing methodology of the hospital (i.e., combined rate or split ward/ICU rate).

BILLING RULES FOR NEWBORNS

		"Healthy" newborn	"Unhealthy" newborn		
			Level of Care Received		
			Standard ward care only	**ICU care only**	**Both standard ward and ICU care**
Billing Methodology	**Combined rate**	healthy newborn rate X number of days	combined rate per diem X number of days		
	Split standard ward/ICU rate	healthy newborn rate X number of days	standard ward care per diem rate X number of days	ICU per diem rate X number of days	***Standard ward and ICU ward stays must be billed on separate lines:*** standard ward care per diem rate X number of days ICU per diem rate X number of days

Note: The healthy newborn rate is not billed when the authorized standard ward care per diem rate and/or the ICU per diem rate is billed.

Refer to Section 5.6 – Standard Ward/Intensive Care Unit Per Diem Rates and Section 5.7 – Rules of Application – Standard Ward/Intensive Care Unit Per Diem Rates of this manual for billing rules and ICU days calculation.

- For a **healthy newborn**, the hospital bills the healthy newborn rate of $1,147 per day with a diagnostic code indicating healthy newborn for the first 30 days; thereafter, the in-patient per diem ward rate is billed.
  - Healthy newborn are defined as those newborns that receive care under the diagnostic code Z38** series only.
  - Submit the in-patient stays for the mother and the newborn on separate claim forms, as different per diem rates apply.

- For a newborn diagnosed as **unhealthy** the hospital can bill the authorized combined, standard ward and/or ICU per diem rate with the applicable diagnostic code.
  - Submit the in-patient stays for the mother and the newborn on the same claim form when the per diem rate is the same for both. Use separate claim forms when the ward rates for each are different.

See Section 5.4 – Hospital Reciprocal In-patient Services Claim Form (AHC0471) – Field Descriptions for important information on completing the ward rate field on the In-patient Services Claim form.

- If the baby is **stillborn**, the hospital can only claim for the mother. Costs associated with a stillborn, including autopsy, are the responsibility of the host jurisdiction.

- Claims for **newborns and for babies up to three months of age** may be submitted using their mother's out-of-province registration number. Claims for babies over three months of age must be submitted using the baby's out-of-province registration number.

- Claims for **twins and triplets up to 1 month of age** may be submitted using their mother's out-of-province registration number. Claims for twins and triplets over 1 month of age must be submitted using the baby's out-of-province registration number.

Hospitals must encourage the out-of-province parent(s) of a newborn to apply immediately for health coverage for their infant. Out-of-province parents need to contact their home province of residence as soon as possible to discuss requirements to register their infant, and to complete the process to obtain a health card/number.

Reciprocal claims submitted for babies over three months of age using a parent's health number are subject to adjustment.

- **Adoption of newborn**
  - Do not submit a claim for the newborn if the mother is temporarily absent from her home province/territory and gives birth in Alberta, and the newborn is being placed for adoption in Alberta or is being placed with an Alberta adoption agency. The newborn will have health care coverage in Alberta effective their date of birth, and the newborn's hospital care costs will be included in the funding the hospital receives from Alberta Health Services.

5.10 Babies Born via Surrogate

A surrogate is defined as a woman who has entered into an arrangement with another party (i.e. the intended parent(s)) to carry a fetus(es) to term, with the intent of surrendering the newborn(s) at birth to the intended parent(s).

In the case where a baby is born via a surrogate, the expectation is that the intended province/territory of residence of the newborn is responsible for providing date-of-birth coverage. If the newborn's registration with the health insurance plan of the intended province/territory of residence is delayed pending the provision of required documentation (e.g., documents demonstrating legal parentage), the expectation is that coverage will be back-dated to date-of-birth, once the required documentation has been received. Onus is on the intended parent(s) to provide the documentation required to register the newborn with the provincial/territorial health insurance plan of residence, as soon as possible.

Do not submit a claim for the newborn born of a surrogacy agreement. Claims for these infants cannot be submitted under the parent's health number. Healthcare coverage for the newborn must first be determined before any billing can occur.

If the intended parent(s) abandon the newborn (i.e., do not honor the surrogacy agreement) coverage for the newborn follows the surrogate.

If the newborn is abandoned by all parties involved, the province/territory where the newborn is resident at the time the abandonment occurred is responsible for first-day coverage.

5.11 Declaration of In-patient Hospital Insurance Coverage Form

In accordance with the reciprocal billing arrangement, a Declaration of Hospital Insurance Coverage Form **must be completed** by the out-of-province patient for all in-patient hospital claims. Incomplete or missing Declaration of Hospital Insurance Coverage forms will result in an adjustment and a loss of revenue for the hospital.

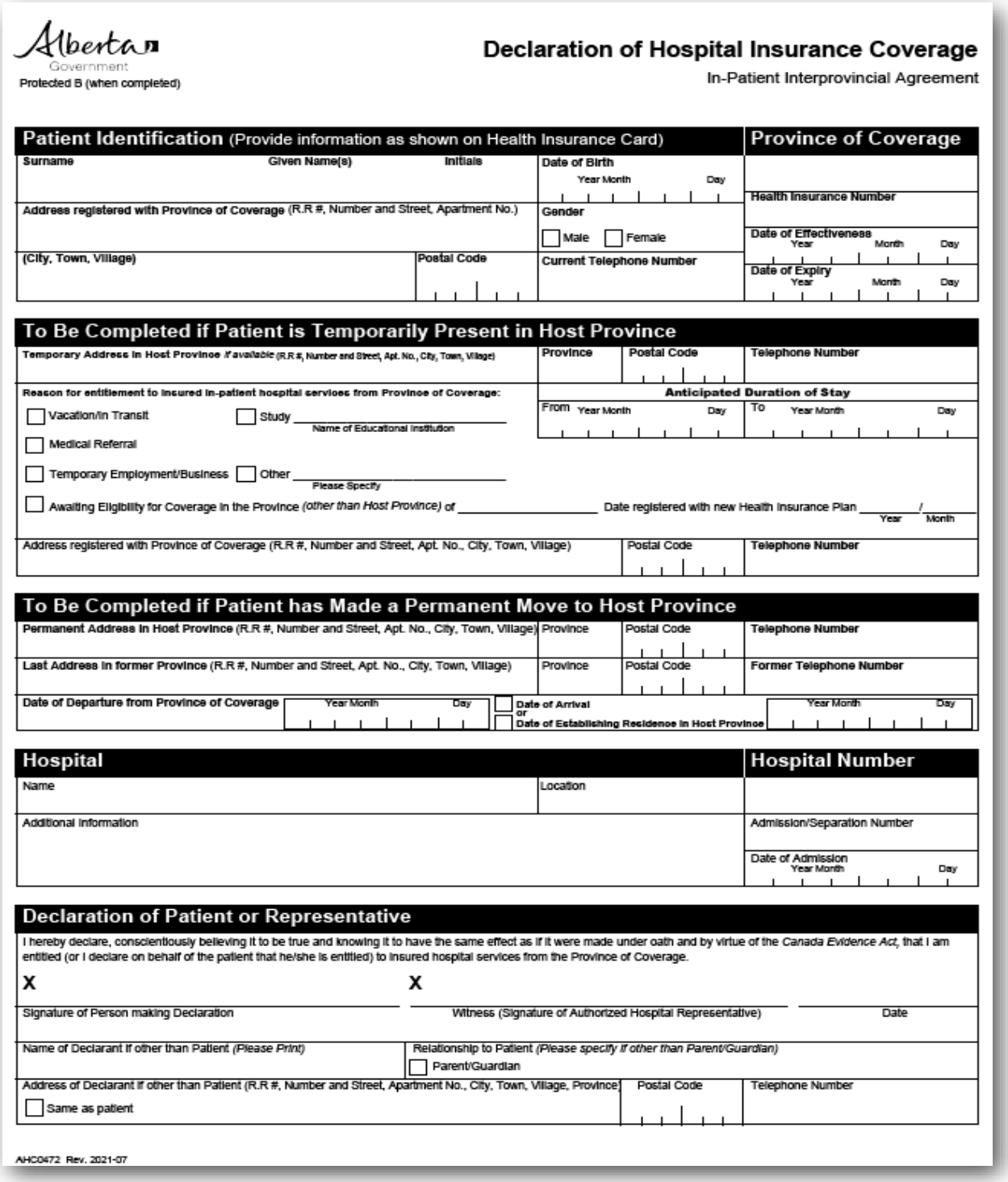
The Declaration of Hospital Insurance Coverage form is not a substitute for the presentation and validation of a valid health card.

The form provides patient contact information and identifies which province/territory is responsible for health care coverage.

Before a claim for in-patient services is submitted, the hospital must ensure the patient (or parent/guardian or spouse on the patient's behalf) has signed a completed declaration form. When a patient is unable to sign a declaration form because of their medical condition, an authorized hospital employee (e.g., unit clerk, registered nurse, registration staff and administrator) may sign the form on the patient's behalf with an explanation of the reason for their signature.

Signed declarations are **mandatory** and need to be retained by the hospital and provided to Alberta Health only when requested. When requested, the declaration must be received by Alberta Health within 30 days of the request date; otherwise, an adjustment will automatically appear on the Statement of Assessment to recover payment.

5.12 Declaration of Hospital Insurance Coverage Form (AHC0472) – Sample



Alberta Government

Protected B (when completed)

Declaration of Hospital Insurance Coverage

In-Patient Interprovincial Agreement

Patient Identification (Provide information as shown on Health Insurance Card) | **Province of Coverage**

Surname | Given Name(s) | Initials | Date of Birth (Year Month Day) | Health Insurance Number

Address registered with Province of Coverage (R.R #, Number and Street, Apartment No.) | Gender: ☐ Male ☐ Female | Date of Effectiveness (Year Month Day)

(City, Town, Village) | Postal Code | Current Telephone Number | Date of Expiry (Year Month Day)

To Be Completed if Patient is Temporarily Present in Host Province

Temporary Address in Host Province if available (R.R #, Number and Street, Apt. No., City, Town, Village) | Province | Postal Code | Telephone Number

Reason for entitlement to insured in-patient hospital services from Province of Coverage: | Anticipated Duration of Stay: From (Year Month Day) To (Year Month Day)

☐ Vacation/In Transit ☐ Study _____ (Name of Educational Institution)

☐ Medical Referral

☐ Temporary Employment/Business ☐ Other _____ (Please Specify)

☐ Awaiting Eligibility for Coverage in the Province *(other than Host Province)* of _____ Date registered with new Health Insurance Plan ____/____ (Year Month)

Address registered with Province of Coverage (R.R #, Number and Street, Apt. No., City, Town, Village) | Postal Code | Telephone Number

To Be Completed if Patient has Made a Permanent Move to Host Province

Permanent Address in Host Province (R.R #, Number and Street, Apt. No., City, Town, Village) | Province | Postal Code | Telephone Number

Last Address in former Province (R.R #, Number and Street, Apt. No., City, Town, Village) | Province | Postal Code | Former Telephone Number

Date of Departure from Province of Coverage (Year Month Day) | ☐ Date of Arrival or ☐ Date of Establishing Residence in Host Province (Year Month Day)

Hospital | **Hospital Number**

Name | Location

Additional Information | Admission/Separation Number | Date of Admission (Year Month Day)

Declaration of Patient or Representative

I hereby declare, conscientiously believing it to be true and knowing it to have the same effect as if it were made under oath and by virtue of the *Canada Evidence Act*, that I am entitled (or I declare on behalf of the patient that he/she is entitled) to insured hospital services from the Province of Coverage.

X _____ Signature of Person making Declaration

X _____ Witness (Signature of Authorized Hospital Representative)

_____ Date

Name of Declarant if other than Patient *(Please Print)*

Relationship to Patient *(Please specify if other than Parent/Guardian)* ☐ Parent/Guardian

Address of Declarant if other than Patient (R.R #, Number and Street, Apartment No., City, Town, Village, Province) | Postal Code | Telephone Number

☐ Same as patient

AHC0472 Rev. 2021-07

5.13 Summary Statement Hospital In-Patient Charges (AHC0483) – Sample

Alberta Government

Protected B (when completed)

Summary Statement Hospital In-Patient Charges

Alberta Health
Hospital Reciprocal Billing
PO Box 1360 Stn Main
Edmonton AB T5J 2N3

Hospital number	Invoice date yyyy mm dd

Hospital name

Code	Province/Territory	Amount
		$

Date submitted	Authorized by

Code	Province/Territory	Code	Province/Territory	Code	Province/Territory
NL	Newfoundland and Labrador	NS	Nova Scotia	PE	Prince Edward Island
NB	New Brunswick	PQ	Quebec	ON	Ontario
MB	Manitoba	SK	Saskatchewan	BC	British Columbia
YT	Yukon	NT	Northwest Territories	NU	Nunavut

6.0 High Cost Procedures

High cost procedures include:

- Organ Procurement (service codes 99 and 100)
- Organ transplants (service codes 101 to 108),
- Special implants and devices (service codes 310 to 323),
- Bone marrow and stem cell transplants (service codes 600 to 607).

High cost procedure claims are submitted on the Hospital Reciprocal In-Patient Services form (AHC0471).

Costs associated with high cost transplants and special implants/devices that are not identified in Sections 6.1 - High Cost Organ Transplants Service Codes & Rates, Section 6.4 – Special Implants/Devices – Service Codes & Rates and Section 6.8 - Bone Marrow & Stem Cell Transplant – Service Codes & Rates but have been identified as meeting reciprocal billing eligibility requirements (i.e. insured by all provinces/territories and are not on the excluded services list) are included within the in-patient per diem rates and therefore shall not be billed separately.

For high cost transplants and special implants/devices that fall outside the reciprocal billing arrangement (i.e., on the excluded services list or not insured by all provinces/territories) contact the patient's home jurisdiction to arrange compensation terms.

6.1 High Cost Organ Transplants Service Codes & Rates

INTERPROVINCIAL BILLING RATES FOR DESIGNATED HIGH COST ORGAN TRANSPLANTS
(Effective for discharges on or after **April 1, 2024**)

SERVICE CODE	DESCRIPTION	RATE($)
	Organ Procurement:	
99	In-Country Organ Procurement.	$34,386
100	Out-of-Country Organ Procurement: The actual out-of-country procurement costs shall be billed. An invoice must accompany the reciprocal billing claim.	
	Organ Transplants:	
101	Heart	$29,686
102	Heart & Lung	$36,012
103	Lung	$23,470
104	Liver	$24,428
106	Kidney	$11,241
108	Kidney & Pancreas	$13,871

The billing model for organ transplants is a mixed model that is comprised of a block rate for the day the procedure is performed including the cost of the transplant itself, and the approved ward and/or ICU rate is billed for the length of the patient stay minus the day of the transplant.

6.2 High Cost Organ Transplants - Rules of Application

1. Any individual organ transplant (example: heart and kidney) shall be billed at the authorized rate during a patient stay. This includes a repeat transplant of the same organ for the same patient.

2. Rates represent the hospital cost associated with the day of the transplant including the cost of the transplant itself. The applicable authorized patient day standard Ward/ICU rate of the hospital providing the transplant shall be billed for the length of the patient stay minus one day for the day of transplant and one day for the discharge date.

3. Each outpatient visit separate from any in-patient stay associated with the high cost procedure shall be billed at the authorized interprovincial outpatient rate.

4. Procurement is defined as all costs associated with the acquisition, storage, shipment, and maintenance of the organ to be transplanted. Procurement includes the hospital and medical cost of maintaining the donor.

5. The recipient's home province/territory is responsible for the associated in-country and out-of-country procurement costs in all cases.

6. In-country and out-of-country procurement costs are not included within the rates. Therefore, code 99 or 100 shall be billed to recoup the cost of organ procurement.

7. An additional amount shall be billed when an artificial heart is implanted as an interim step prior to a natural heart transplant.

8. A province/territory shall bill the transplant recipient's province/territory for the provision of donor testing or preparation services using the transplant recipient's health card number. The province/territory providing the donor testing or preparation services shall bill the transplant patient's province/territory regardless of whether the donor tests positive or negative for transplantation.

9. Transplants listed on this rate schedule represent those high cost transplants for which a separate rate has been approved. For transplants that are not listed herein, only the per diem rate can be billed.

BILLING SCENARIOS FOR HIGH COST ORGAN TRANSPLANTS

	Scenario 1		Scenario 2		Scenario 3	
		Cost ($)		Cost ($)		Cost ($)
Examples:						
Organ Transplant Type:	Heart		Heart		Lung	
Admission Date:	2024/04/01		2024/08/15		2024/08/01	
Discharge Date:	2024/04/10		2024/09/28		2024/09/10	
HCP Date:	2024/04/02		2024/08/18		2024/08/08	
Ward Rate:	$1,108		$1,108		$1,108	
ICU Rate:	$5,432		$5,432		$5,432	
STEP 1 - Determining Length of Stay Cost						
Total Days (minus the day of transplant & discharge date)	8		43		39	
# of Ward Days	0	$0	19	$21,052	15	$16,620
# of ICU Days	8	$43,456	24	$130,368	24	$130,368
STEP 2 – Apply Block Rate for HCP						
Transplant block Rate	Code 101	$29,686	Code 101	$29,686	Code 103	$23,470
STEP 3 – Determine if Artificial Heart required						
Was an artificial heart implanted prior to natural heart transplant?	No		Yes		N/A	
Cost of Artificial Heart				$95,000	N/A	
STEP 4 – Determine procurement cost						
In-country Organ Procurement	Yes	$34,386	No		Yes	$34,386
Out-of-Country Organ Procurement	No		Yes	$20,000	No	
STEP 5 – Confirm billing codes & amounts to claim						
Total Per Diem Cost Claimed (Ward + ICU)		**$43,456**		**$151,420**		**$146,988**
HCP Claimed	**Code 101**	**$29,686**	**Code 101**	**$29,686**	**Code 103**	**$23,470**
Procurement Cost Claimed	**Code 99**	**$34,386**	**Code 100**	**$20,000**	**Code 99**	**$34,386**
Artificial Heart Claimed	**-**	**-**		**$95,000**	**-**	**-**

6.3 High Cost Organ Transplants - Claim Submission Guidelines

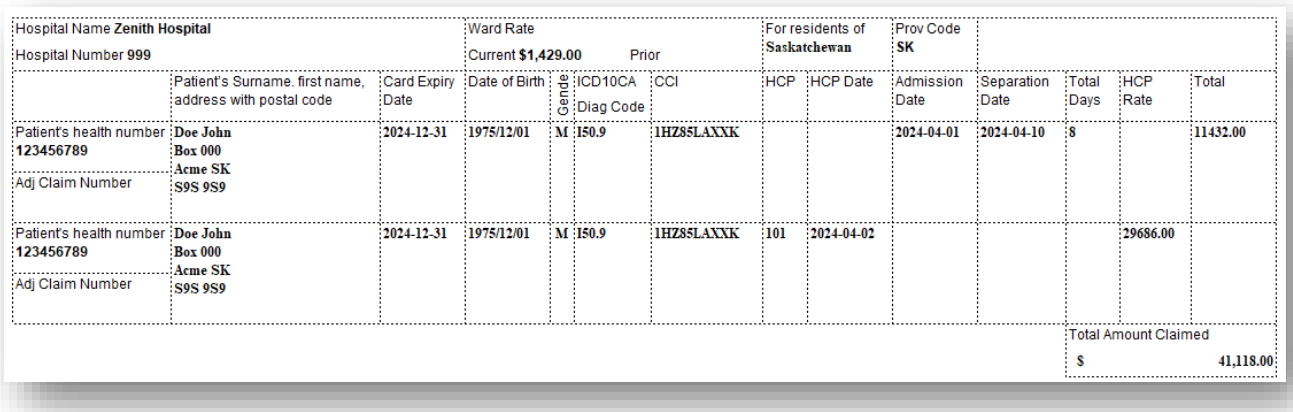
Transplants – service codes 101 to 108

The rates for transplant services codes 101 to 108 represent the hospital cost associated with the day of the transplant itself. The appropriate in-patient per diem Ward/ICU rate of the hospital performing the transplant may be billed for the length of the patient stay minus one day for the day of transplant (and 1 day for the date of discharge). **Two claim lines** must be submitted when these procedures are performed.

- The first claim line identifies the per diem information. Enter all patient identification details (health number, name and address, card expiry date [if applicable], date of birth, gender), plus:
  - ICD10CA diagnostic code(s)
  - CCI Procedure Code
  - Admission date
  - Separation date
  - Total days
  - Total (the amount claimed for the in-patient stay)

> When submitting claims for standard ward or ICU in-patient stays, the per diem hospital rate is multiplied by the number of days hospitalized, less two days – one for the transplant and one for the discharge date.

- The second claim line identifies the high cost procedure information. Enter all patient identification details (health number, name and address, card expiry date [if applicable], date of birth, gender), plus:
  - ICD10CA diagnostic code(s)
  - CCI Procedure Code
  - High cost procedure code
  - High cost procedure date
  - Total (the amount claimed for the procedure)
- Leave the following fields **blank** on the second claim line:
  - Admission date
  - Separation date
  - Total days



Hospital Name **Zenith Hospital** Hospital Number **999**			Ward Rate Current **$1,429.00** Prior				For residents of **Saskatchewan**	Prov Code **SK**					
	Patient's Surname. first name, address with postal code	Card Expiry Date	Date of Birth	Gende	ICD10CA Diag Code	CCI	HCP	HCP Date	Admission Date	Separation Date	Total Days	HCP Rate	Total
Patient's health number **123456789** Adj Claim Number	**Doe John** **Box 000** **Acme SK** **S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**I50.9**	**1HZ85LAXXK**			**2024-04-01**	**2024-04-10**	**8**		**11432.00**
Patient's health number **123456789** Adj Claim Number	**Doe John** **Box 000** **Acme SK** **S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**I50.9**	**1HZ85LAXXK**	**101**	**2024-04-02**				**29686.00**	
											Total Amount Claimed **$ 41,118.00**		

Organ procurement - service codes 99 and 100

If an organ is acquired, service code 99 (In-Country Procurement) or service code 100 (Out-of-Country Organ Procurement) is billed in addition to service code 101 to 108. **Three claim lines** must be submitted. Enter all the patient identification details on all three claim lines

For service code 100, submit a copy of the invoice for the out of country procurement with the claim. If the invoice is not provided, the claim is refused.

- On the first claim line, submit code 99 to bill the listed in-country procurement cost or service code 100 to bill the invoice cost for out-of-country procurement.
- On the second claim line, submit the applicable high cost transplant code (101 to 108) at the listed rate.
- On the third claim line, indicate the admission and discharge dates with the total of the in-patient stay.

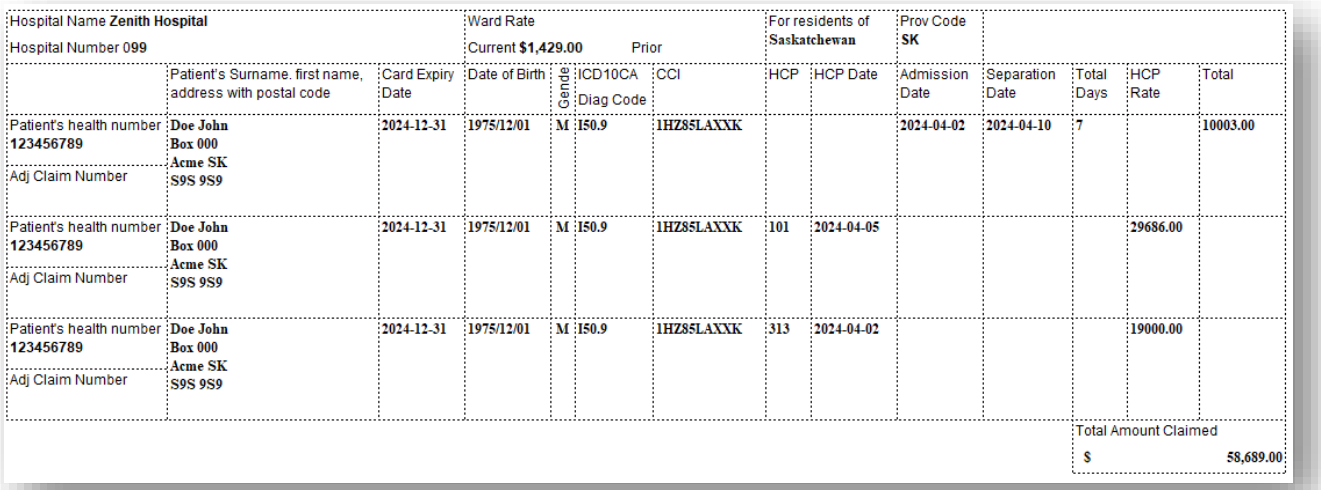
Hospital Name **Zenith Hospital** Hospital Number 099			Ward Rate Current **$1,429.00** Prior				For residents of **Saskatchewan**	Prov Code **SK**					
	Patient's Surname. first name, address with postal code	Card Expiry Date	Date of Birth	Gende	ICD10CA Diag Code	CCI	HCP	HCP Date	Admission Date	Separation Date	Total Days	HCP Rate	Total
Patient's health number **123456789** Adj Claim Number	**Doe John** **Box 000** **Acme SK** **S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**I50.9**	**1HZ85LAXXK**	**100**	**2024-04-02**				**20000.00**	
Patient's health number **123456789** Adj Claim Number	**Doe John** **Box 000** **Acme SK** **S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**I50.9**	**1HZ85LAXXK**	**101**	**2024-04-02**				**29686.00**	
Patient's health number **123456789** Adj Claim Number	**Doe John** **Box 000** **Acme SK** **S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**I50.9**	**1HZ85LAXXK**			**2024-04-01**	**2024-04-10**	**8**		**11432.00**
											Total Amount Claimed **$**		**61,118.00**

Billing service code 101 with an artificial heart

An additional amount can be billed when an artificial heart is implanted as an interim step prior to a natural heart transplant. **Three claim lines** must be submitted.

- The first claim line identifies the per diem information for the period of the in-patient stay. Indicate the admission and discharge dates with the total of the in-patient stay.
- The second claim line identifies the high cost procedure information for code 101 at the listed rate.
- The third claim line identifies the artificial heart (code 313). Leave the following fields blank:
  - Admission date
  - Separation date
  - Total Days

Billing service codes 101 to 108 spanning a Ward and ICU stay



Hospital Name **Zenith Hospital**
Hospital Number **099**

Ward Rate
Current **$1,429.00** Prior

For residents of **Saskatchewan**

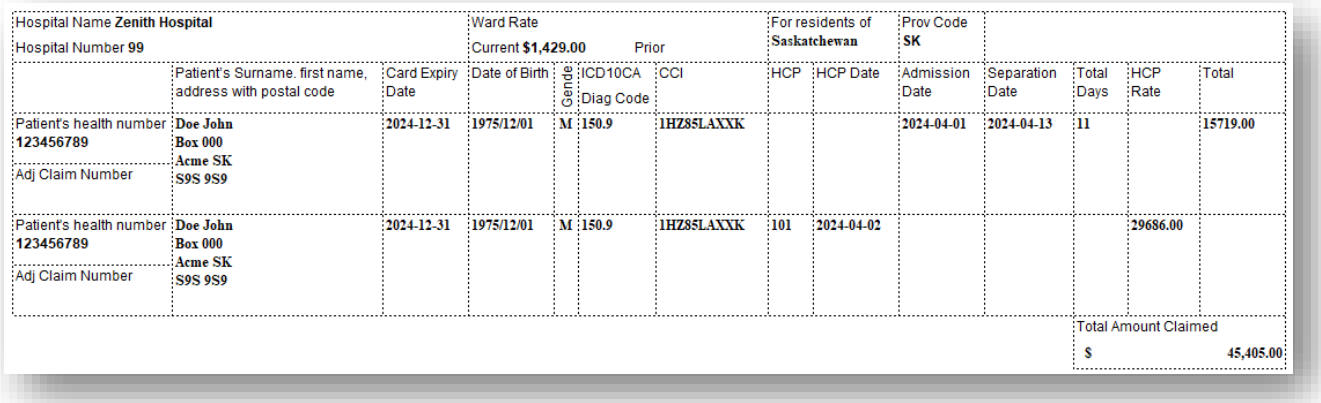
Prov Code **SK**

	Patient's Surname, first name, address with postal code	Card Expiry Date	Date of Birth	Gende	ICD10CA Diag Code	CCI	HCP	HCP Date	Admission Date	Separation Date	Total Days	HCP Rate	Total
Patient's health number **123456789** Adj Claim Number	**Doe John Box 000 Acme SK S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**I50.9**	**1HZ85LAXXK**			**2024-04-02**	**2024-04-10**	**7**		**10003.00**
Patient's health number **123456789** Adj Claim Number	**Doe John Box 000 Acme SK S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**I50.9**	**1HZ85LAXXK**	**101**	**2024-04-05**				**29686.00**	
Patient's health number **123456789** Adj Claim Number	**Doe John Box 000 Acme SK S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**I50.9**	**1HZ85LAXXK**	**313**	**2024-04-02**				**19000.00**	

Total Amount Claimed
$ **58,689.00**

Initial in-patient admission and transplant done in the regular ward; then transferred and discharged from the ICU. There is no organ procurement, nor transfer back to regular ward.

- **Two claims** must be submitted when the hospitalization spans a Ward and ICU stay.
  - The first claim includes the per diem at the time of the transplant (Ward or ICU) and the day of the transplant (code 101 to 108).
  - The second claim includes the per diem where patient is hospitalized following the transplant with different level of care.



Hospital Name **Zenith Hospital**
Hospital Number **99**

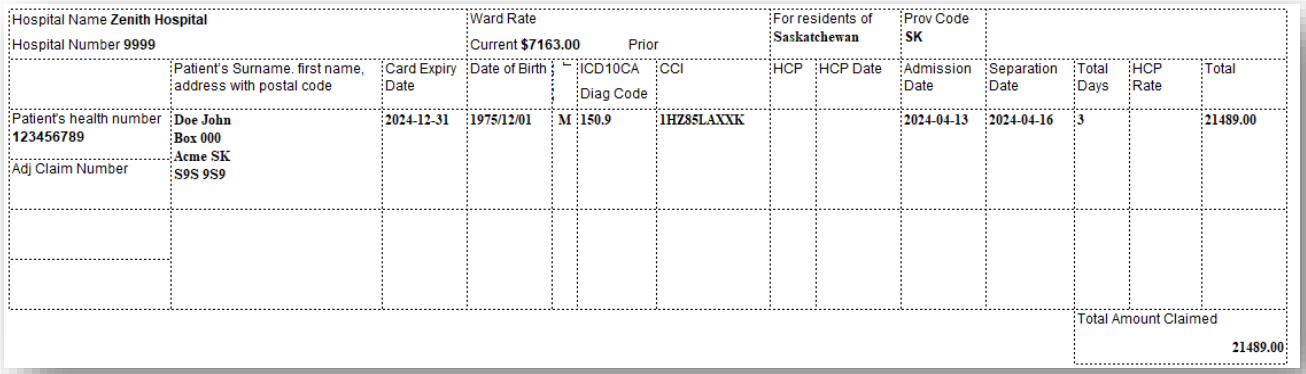
Ward Rate
Current **$1,429.00** Prior

For residents of **Saskatchewan**

Prov Code **SK**

	Patient's Surname, first name, address with postal code	Card Expiry Date	Date of Birth	Gende	ICD10CA Diag Code	CCI	HCP	HCP Date	Admission Date	Separation Date	Total Days	HCP Rate	Total
Patient's health number **123456789** Adj Claim Number	**Doe John Box 000 Acme SK S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**150.9**	**1HZ85LAXXK**			**2024-04-01**	**2024-04-13**	**11**		**15719.00**
Patient's health number **123456789** Adj Claim Number	**Doe John Box 000 Acme SK S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**150.9**	**1HZ85LAXXK**	**101**	**2024-04-02**				**29686.00**	

Total Amount Claimed
$ **45,405.00**



Hospital Name **Zenith Hospital** Hospital Number **9999**			Ward Rate Current **$7163.00** Prior				For residents of **Saskatchewan**	Prov Code **SK**					
	Patient's Surname. first name, address with postal code	Card Expiry Date	Date of Birth		ICD10CA Diag Code	CCI	HCP	HCP Date	Admission Date	Separation Date	Total Days	HCP Rate	Total
Patient's health number **123456789** Adj Claim Number	**Doe John** **Box 000** **Acme SK** **S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**150.9**	**1HZ85LAXXK**			**2024-04-13**	**2024-04-16**	**3**		**21489.00**
											Total Amount Claimed **21489.00**		

- Initial in-patient admission in the regular ward; transferred to ICU where the transplant is done; transferred back to regular ward where discharged**.** Organ procurement costs are incurred.
- **Two claims** must be submitted when the hospitalization spans a Ward and ICU stay, and where the patient is transferred back to the regular ward prior to discharge.
  - The first claim includes the first Ward stay prior to the transfer to ICU and the second ward stay prior to discharge. For the regular ward at the time of the transplant (Ward or ICU) and the day of the transplant.
  - The second claim includes the per diem for the day of the transplant (code 101 to 108) and for the ICU stay where the patient was hospitalized following the transplant prior to being transferred back to the regular Ward. Costs associated with the organ procurement are also claimed (code 99 or 100).

To ensure the accurate and timely payment of claims, these claims must be submitted together as shown below **and not separated or each claim sent on different days/weeks**. (Please refer to Section 5.6 - Standard Ward/Intensive Care Unit Per Diem Rates on proper claim submission).

Hospital Name **Zenith Hospital** Hospital Number **99**			Ward Rate Current **$2,238** Prior				For residents of **Saskatchewan**		Prov Code **SK**				
	Patient's Surname. first name, address with postal code	Card Expiry Date	Date of Birth		ICD10CA Diag Code	CCI	HCP	HCP Date	Admission Date	Separation Date	Total Days	HCP Rate	Total
Patient's health number **123456789** Adj Claim Number	**Doe John** **Box 000** **Acme SK** **S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**150.9**	**1HZ85LAXXK**			**2024-07-12**	**2024-07-13**	**1**		**2238.00**
Patient's health number **123456789** Adj Claim Number	**Doe John** **Box 000** **Acme SK** **S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**150.9**	**1HZ85LAXXK**			**2024-07-16**	**2024-07-27**	**11**		**24618.00**
											Total Amount Claimed **$**		**26,856.00**

Hospital Name **Zenith Hospital** Hospital Number **9999**			Ward Rate Current **$7,277.00** Prior				For residents of **Saskatchewan**		Prov Code **SK**				
	Patient's Surname. first name, address with postal code	Card Expiry Date	Date of Birth		ICD10CA Diag Code	CCI	HCP	HCP Date	Admission Date	Separation Date	Total Days	HCP Rate	Total
Patient's health number **123456789** Adj Claim Number	**Doe John** **Box 000** **Acme SK** **S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**150.9**	**1HZ85LAXXK**			**2024-07-13**	**2024-07-16**	**2**		**14554.00**
Patient's health number **123456789** Adj Claim Number	**Doe John** **Box 000** **Acme SK** **S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**150.9**	**1HZ85LAXXK**	**99**	**2024-07-13**				**34,386**	
Patient's health number **123456789** Adj Claim Number	**Doe John** **Box 000** **Acme SK** **S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**150.9**	**1HZ85LAXXK**	**104**	**2024-07-13**				**24428**	
											Total Amount Claimed **$**		**73,368.00**

Billing when transplant recipient passes away during organ transplant

If the organ transplant recipient passes away during the surgery, the day of the transplant and day of discharge are the same. Codes 101 to 108 can be billed for the day of the transplant.

Scenario: During the transplant surgery recipient passes away during the operation.

Admission date:	April 5, 2024
Transplant date:	April 7, 2024
Date of death:	April 7, 2024

If your claim was refused or paid incorrectly, please contact the HMR unit by email (HMR.Unit@gov.ab.ca) as soon as possible.

- As the date of death occurred on April 7th, this would also be considered the discharge date for billing purposes.

- On the claim line that identifies the per diem information for the length of patient stay from admission to date of death:
  – Complete all required fields with an admission date of April 5, 2024 and a discharge date of April 7, 2024 at the 2024/2024 approved rate; minus one day for the date of discharge.

- On the claim line that identifies the high cost organ transplant information:
  – Complete all required fields using the applicable high cost organ transplant code (101 to 108) at the listed rate with a date of transplant of April 7, 2024.

Hospital Name **Zenith Hospital** Hospital Number **999**			Ward Rate Current **$1,429.00** Prior				For residents of **Saskatchewan**		Prov Code **SK**				
	Patient's Surname, first name, address with postal code	Card Expiry Date	Date of Birth	Gende	ICD10CA Diag Code	CCI	HCP	HCP Date	Admission Date	Separation Date	Total Days	HCP Rate	Total
Patient's health number **123456789** Adj Claim Number	**Doe John** **Box 000** **Acme SK** **S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**150.9**	**1HZ85LAXXK**			**2024-04-05**	**2024-04-07**	**2**		**2858.00**
Patient's health number **123456789** Adj Claim Number	**Doe John** **Box 000** **Acme SK** **S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**150.9**	**1HZ85LAXXK**	**101**	**2024-04-07**				**29686.00**	
											Total Amount Claimed **$**		**32,544.00**

Billing when patient's eligibility changes during hospitalization

When a transplant recipient's eligibility changes during the in-patient stay; the jurisdiction covering the patient is responsible for the cost of the in-patient stay up to or following the eligibility change.

For the solid organ transplant, the jurisdiction covering the patient on the day of transplant is responsible for the costs of the transplant.

Scenario: Patient's eligibility changes during hospitalization for lung transplant.

- Individual moves from jurisdiction A to jurisdiction B on April 15, 2024.
- Individual applies for coverage in jurisdiction B which will be effective on July 1, 2024.
- Individual is admitted into hospital in jurisdiction B on May 1, 2024 for lung transplant.
- Transplant occurs on May 3, 2024.
- Patient is discharged on July 15, 2024.

As the lung transplant occurred while the individual was covered under jurisdiction A, jurisdiction A is responsible for the cost of the transplant. The hospital in jurisdiction B would submit two claim lines:

- On the claim line that identifies the per diem information for the length of patient stay from admission to date of eligibility change:
  – Jurisdiction B would complete all required fields with an admission date of May 1, 2024 and a discharge date of July 1, 2024 at the 2024/2024 approved rate; minus one day for the date of transplant and one day for the date of discharge.

- On the claim line that identifies the high cost organ transplant information:
  – Jurisdiction B would complete all required fields using the applicable high cost organ transplant code (101 to 108) at the listed rate with a date of transplant of May 3, 2024.

Following the eligibility change on July 1, 2024; Jurisdiction B will be responsible for the cost of the in-patient stay from July 1, 2024 to the discharge date of July 15, 2024.

Hospital Name **Zenith Hospital** Hospital Number **999**			Ward Rate Current **$1,429.00** Prior				For residents of **Saskatchewan**		Prov Code **SK**				
	Patient's Surname, first name, address with postal code	Card Expiry Date	Date of Birth	Gende	ICD10CA Diag Code	CCI	HCP	HCP Date	Admission Date	Separation Date	Total Days	HCP Rate	Total
Patient's health number **123456789** Adj Claim Number	**Doe John** **Box 000** **Acme SK** **S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**150.9**	**1HZ85LAXXK**			**2024-05-01**	**2024-07-01**	**60**		**85740.00**
Patient's health number **123456789** Adj Claim Number	**Doe John** **Box 000** **Acme SK** **S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**150.9**	**1HZ85LAXXK**	**103**	**2024-05-03**				**23470.00**	
											Total Amount Claimed **$**		**109,210.00**

6.4 Special Implants/Devices – Service Codes & Rates

INTERPROVINCIAL BILLING SPECIAL IMPLANT/DEVICE RATES
(Effective for interventions on or after **April 1, 2024**)

For a special implant/device costing $2,000 or more, the rate is the invoiced price of the special implant/device plus the authorized per diem rate(s) of the hospital for any associated in-patient days of stay.

SERVICE CODE	DESCRIPTION
310	Cochlear implants
311	Cardiac pacemakers and/or defibrillators (any type) ICD etc.
312	Aortic valve (aka TAVI)
313	Ventricular assist device (VAD)
314	Abdominal aorta knitted grafts, stents
315	Cranium screws, wires, mesh, plates used in release/repair
316	Implantation, thalamus and basal ganglia, of electrodes using burr hole approach
317	Artificial knee used in bilateral and unilateral revision/replacement
318	Spinal fixation/fusion rods, grafts, screws
319	Artificial hip used in unilateral replacement (excludes bilateral and revised)
320	Artificial shoulder used in shoulder revision/replacement
321	Stent grafts
322	Expandable stent graft used in endovascular aneurysm repairs (EVAR)
323	Transcatheter pulmonary valve

See Appendix D – CCI codes for High Cost Procedures

6.5 Special Implants/Devices – Rules of Application

1. Where the total invoice cost of the implants/devices is under $2,000, only the per diem is billable.

2. Where the total invoice cost of the implants/devices is $2,000 or greater, the invoice cost shall be billed in addition to the authorized in-patient per-diem for the hospital and a copy of the supplier invoice must be provided to the home jurisdiction.

3. Claims must be accompanied by an invoice. The invoice must be the official invoice from the manufacturer. If individual items inserted during the procedure (e.g., implants, device, mesh, pins, screws, etc.) cost less than $500, supporting documentation (facility invoice or other) may be submitted in place of a supplier invoice. (Section 6.6 – Billing for Special Implants/Devices)

Any claims not accompanied by invoices will not be paid as the other jurisdictions require copies.

4. Aortic valve (aka TAVI) involves the implantation of xenograft aortic valve replacement without excision of native valve, via transcatheter approach.

5. VAD (such as Berlin Heart) includes the mechanical pump (all forms: external, implanted or paracorporeal), implant kit, external controller with backup, main AC power source with patient cables, batteries, charger, DC adapter for car, monitor to communicate information regarding VAD function and to enable program setting changes to VAD controller, and necessary accessories including cannulae and circuits specific to the device, blow flow Doppler, water proof VAD shower bag, vests, battery holster and belts.

6. Stent graft procedure is a procedure that uses percutaneous transluminal approach and (endovascular) stent with synthetic graft. EVAR related CCI codes are excluded from this procedure group.

7. Endovascular aneurysm repair or endovascular aortic repair (EVAR) is a type of endovascular surgery used to treat an abdominal aortic aneurysm. The procedure involves the placement of an expandable stent graft within the aorta to treat the aortic disease without surgically opening or removing part of the aorta.

8. Pulmonary valve treatment is a procedure wherein an artificial heart valve is delivered via catheter through the cardiovascular system. The catheter is inserted into the patient's femoral vein through a small access site. The catheter which holds the valve is placed in the vein and guided into the patient's heart. Once the valve is in the right position, the balloons are inflated, and the valve expands into place and blood will flow between the patient's right ventricle and lungs.

6.6 Billing for Special Implants/Devices

Item	Scenario 1		Scenario 2		Scenario 3	
	Cost ($)	**Information Required on Invoice**	**Cost ($)**	**Information Required on Invoice**	**Cost ($)**	**Information Required on Invoice**
Mesh	200	Not applicable	200	Facility Cost	200	Facility Cost
Screw 1	550	Not applicable	300	Facility Cost	500	Supplier Cost
Screw 2	200	Not applicable	200	Facility Cost	200	Facility Cost
Wire	0		400	Facility Cost	200	Facility Cost
Pacemaker	1,000	Not applicable	1,000	Supplier Cost	1,000	Supplier Cost
Total	**1,950**		**2,100**		**2,100**	
Billable Amount:	**Per Diem Only**		**2,100**		**2,100**	
Accompanying Invoice Needed:	None		- 1 facility generated invoice listing: mesh, screw 1, screw 2 and wire - supplier generated invoice for: pacemaker		- 1 facility generated invoice listing: mesh, screw 2 and wire. - if items from different supplier separate supplier invoices for: screw 1, pacemaker - if items from same supplier, one supplier invoice for: screw 1, pacemaker	

Facility Generated Invoice:
If any specific component used during a procedure (e.g., a screw) has a unit cost of less than $500.00 (e.g., $120.00 each), regardless of how many may be used, it is acceptable to list this information on one facility generated invoice. Additionally, any other components costing less than $500.00 each; regardless of how many are used; can be added onto the same facility generated invoice.

Supplier Generated Invoice:
If any specific component used during a procedure (e.g., pacemaker) has a unit cost of $500.00 or more (e.g., $510.00 each), regardless of how many may be used, it is acceptable to identify this component on the respective supplier invoice. Additionally, any other components with a cost of $500.00 or more each; regardless of how many are used; should be identified on the respective supplier invoice.

6.7 Special Implants/Devices Codes 310 to 323 – Claim Submission Guidelines

Hospitals may bill the invoice price of the special implanted device plus the authorized per diem rate for any associated in-patient days of stay. Two claim lines must be submitted:

- The first claim line is for the per diem days. Complete all required fields, including the total per diem amount claimed in the “Total” field.

- The second claim line is for the implant device. Enter all patient identification details (health number, name and address, card expiry date [if applicable], date of birth, gender), plus:
  - ICD10CA diagnostic code(s)
  - CCI Procedure Code
  - High cost procedure code
  - High cost procedure date
  - Total (the claimed amount for the implant device)

Leave the following fields **blank** on the second claim line:
- Admission date
- Separation date
- Total Days
- High cost procedure rate

The invoice for the device **must** be submitted with the claim.

Hospital Name **Zenith Hospital** Hospital Number **999**			Ward Rate Current **$1429.00** Prior				For residents of **Saskatchewan**	Prov Code **SK**					
	Patient's Surname, first name, address with postal code	Card Expiry Date	Date of Birth	Gende	ICD10CA Diag Code	CCI	HCP	HCP Date	Admission Date	Separation Date	Total Days	HCP Rate	Total
Patient's health number **123456789** Adj Claim Number	**Doe John** **Box 000** **Acme SK** **S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**C83.8**	**2MA71HA**			**2024-04-01**	**2024-04-13**	**12**		**17148.00**
Patient's health number **123456789** Adj Claim Number	**Doe John** **Box 000** **Acme SK** **S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**C83.8**	**2MA71HA**	**311**	**2024-04-05**					**30052.00**
											Total Amount Claimed		**47200.00**

Do not submit a per diem claim with a "zero" ward rate if you were previously paid for the per diem days and are now submitting a claim for the special implant. Submit the claim for the special implant only and enter the ward rate in the ward rate field on the claim form.

6.8 Bone Marrow & Stem Cell Transplant – Service Codes & Rates

INTERPROVINCIAL BILLING RATES FOR BONE MARROW AND STEM CELL TRANSPLANT SERVICES
(Effective for discharges on or after **April 1, 2024**)

Service Code	Service Category	Maximum Length of Stay (MLOS)	Basic Block Rate	Add-on Standard High Cost Per Diem over MLOS
600	Acquisition costs (outside Canada) includes Monoclonal Antibody	--	Invoice Cost	Invoice Cost
601	Adult Autologous <72 hour discharge	--	$39,697	--
602	Paediatric Autologous <72 hour discharge	--	$47,635	--
603	Adult Autologous >72 hour	16 days	$89,325	$3,309
604	Paediatric Autologous >72 hour	13 days	$119,098	$5,953
605	Adult Allogeneic excl. matched unrelated donor (MUD) patients	25 days	$205,554	$3,534
606	Paediatric Allogeneic	25 days	$254,518	$6,397
607	Adult Allogeneic MUD patients	25 days	$248,122	$3,534

6.9 Bone Marrow & Stem Cell Transplant – Rules of Application

1. Any in-patient stay, separate and distinct from an admission for a bone marrow/stem cell transplant (i.e., for pre-procedure assessment, stabilization, etc.), shall be billed at the applicable authorized patient day standard ward or ICU rate of the hospital providing the transplant.

2. Each outpatient visit shall be billed at the authorized interprovincial outpatient rate.

3. Each block rate includes all facility costs associated with a single transplant episode including in-patient and diagnostic costs. For purposes of calculating the Maximum Length of Stay, the in-patient stay includes the date of admission but not the date of discharge.

4. The Add-on Standard High Cost Per Diem shall be billed for in-patient days in excess of the Maximum Length of Stay during the in-patient admission in which the transplant was performed.

5. Acquisition Costs:

- When bone marrow/stem cell is acquired within Canada, the costs are included in the block rate. The transplant centre is responsible for paying the acquisition cost.
- When bone marrow/stem cell is acquired from outside Canada, the actual invoice cost paid by the transplant centre shall be billed to the recipient's province/territory of residence. The actual invoice must accompany the reciprocal billing claim.

6. Patients discharged within 72 hours from date of procedure shall be billed at the 72-hour discharge (adult or paediatric) rate by the hospital which performed the transplant service.

7. Paediatric refers to a person 17 years of age and under.

8. Persons who are discharged and develop complications related to a bone marrow or stem cell transplant, shall be re-admitted for in-patient stays at the applicable authorized patient day standard ward or ICU rate of the hospital and not the Add-on Standard High Cost Per Diem.

9. Any repeat in-patient stay for the same patient for a repeat bone marrow or stem cell transplant shall be treated as a new case and shall be billable as described in these Rules.

10. With the exception of acquisition costs in 5(b), claims for bone marrow/stem cell transplants shall be billed as a complete claim at the time of discharge.

11. Diagnostic coding is mandatory and shall indicate the principal cause or final diagnosis of the transplant case.

12. Bone marrow/stem cell transplants performed as part of clinical trials or for diagnoses for which the treatment is still considered experimental are not eligible for reciprocal billing.

6.10 Bone Marrow & Stem Cell Transplant Codes 600-607 – Claims Submission Guidelines

1. Claims for service codes 600 to 607 are to be submitted on separate forms from claims for the other high cost procedure service codes (99-108, 310-323)

2. When these procedures are performed, one claim is submitted as described below:

- **For service codes 601 – 602:** enter all patient identification details (health number, name and address, card expiry date [if applicable], date of birth, gender) and:
  - ICD10CA diagnostic code(s)
  - CCI procedure code
  - High cost procedure code and high cost procedure date
  - Total (the basic block rate for the procedure)
  - Leave the ward rate field blank

Hospital Name **Zenith Hospital**			Ward Rate				For residents of	Prov Code					
Hospital Number **999**			Current		Prior		**Saskatchewan**	**SK**					
	Patient's Surname. first name, address with postal code	Card Expiry Date	Date of Birth	Gende	ICD10CA Diag Code	CCI	HCP	HCP Date	Admission Date	Separation Date	Total Days	HCP Rate	Total
Patient's health number **123456789**	**Doe John Box 000 Acme SK S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**C83.8**	**2MA71HA**	**601**	**2024-04-05**					**39697.00**
Adj Claim Number													
											Total Amount Claimed		
											$		**39,697.00**

- **For service codes 603 – 607 where MLOS add-on is not being billed:** enter all patient identification details and:
  - ICD10CA diagnostic code(s) and CCI procedure code

Hospital Name **Zenith Hospital**			Ward Rate				For residents of	Prov Code					
Hospital Number **999**			Current		Prior		**Saskatchewan**	**SK**					
	Patient's Surname. first name, address with postal code	Card Expiry Date	Date of Birth	Gende	ICD10CA Diag Code	CCI	HCP	HCP Date	Admission Date	Separation Date	Total Days	HCP Rate	Total
Patient's health number **123456789**	**Doe John Box 000 Acme SK S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**C83.8**	**2MA71HA**	**603**		**2024-04-01**	**2024-04-13**	**12**		**89325.00**
Adj Claim Number													
											Total Amount Claimed		
											$		**92,252.00**

  - High cost procedure code
    - Admission and separation date
    - Total days
    - Total (the basic block rate for the procedure)
    - Leave the ward rate field blank

- **For service codes 603 – 607 where MLOS add-on is being billed:** enter all patient identification details and:
  - ICD10CA diagnostic code(s) and CCI procedure code
  - High cost procedure code
  - Admission and separation date
  - Total days
  - Total (the total of the basic block rate for the procedure **and** the add-on cost per diem over the block rate)
  - Leave the ward field blank

Hospital Name **Zenith Hospital**			Ward Rate				For residents of	Prov Code					
Hospital Number **999**			Current		Prior		**Saskatchewan**	**SK**					
	Patient's Surname. first name, address with postal code	Card Expiry Date	Date of Birth	Gende	ICD10CA Diag Code	CCI	HCP	HCP Date	Admission Date	Separation Date	Total Days	HCP Rate	Total
Patient's health number **123456789**	**Doe John Box 000 Acme SK S9S 9S9**	**2024-12-31**	**1975/12/01**	**M**	**C83.8**	**2MA71HA**	**603**		**2024/04/01**	**2024/04/20**	**19**		**89325.00**
Adj Claim Number													
											Total Amount Claimed		
											$		**89,325.00**

3. A claim for service code 600 may be submitted in addition to the claim for the procedure when bone marrow/stem cell is acquired from outside Canada. On this claim enter all patient identification details and:
   - ICD10CA diagnostic code(s) and CCI procedure code
   - High cost procedure code (600)
   - Admission and separation date
   - Total days
   - Total (the invoice cost of the material)

4. Bone marrow/stem cell rates are block rates inclusive of any length of in-patient stay (Section 5.8 Intensive Care Unit Days – Calculation and Billing). For these block rates, the date of discharge is used for billing purposes regardless of services being provided over two fiscal years.

6.11 Cost Sharing for Bone Marrow/Stem Cell Transplants When Patient's Eligibility Changes During Hospitalization

For bone marrow/stem cell transplants, the cost of the service is shared between the jurisdictions on a pro-rated basis whereby the jurisdiction covering the patient on the day of hospitalization is responsible for the costs up to the eligibility change.

The host and home jurisdictions will agree how to accommodate the pro-rated amount within their respective billing systems. Alberta Hospitals should contact the Hospital Reciprocal Billing Unit for direction on how to submit the claim. The pro-rated amount is calculated as follows:

For bone marrow/stem cell transplants where admission is longer than the Maximum Length of Stay (MLOS):

1. Calculate the daily rate of the transplant costs:

   a) For bone marrow/stem cell transplants, this is the (block rate plus the add-on costs for the additional days past the MLOS)/number of days admitted less 1 day.

   b) Multiply the daily rate by the number of days the patient was eligible under the former jurisdiction's coverage.

2. Submit the pro-rated amount and provide letter/documentation stating the change in eligibility and the calculation.

For bone marrow/stem cell transplants where admission and discharge are less than or equal to the MLOS:

1. Calculate the pro-rated percentage

2. Submit the pro-rated amount and provide letter/documentation stating the change in eligibility and the calculation.

   Example:
   - Resident moves from jurisdiction A to jurisdiction B on January 15
   - Applies for coverage in jurisdiction B which will be effective on April 1
   - Is admitted into hospital in jurisdiction B on March 27 for adult allogeneic stem cell transplant (code 607)
   - Transplant occurs on March 28 and patient discharged on April 17 (total length of admission = 21 days)
   - Transplant rate for code 607 = $248,122 (up to 25 days admission)
   - Pro-rated cost = $248,122* (5/21) = $59,076.67
   - Cost to Jurisdiction A is $59,076.67

Admission date on the reciprocal claim is March 27 and discharge date is April 1st..Jurisdiction B and Jurisdiction A would work together to determine how the apportioned rate will be accommodated within their respective billing systems.

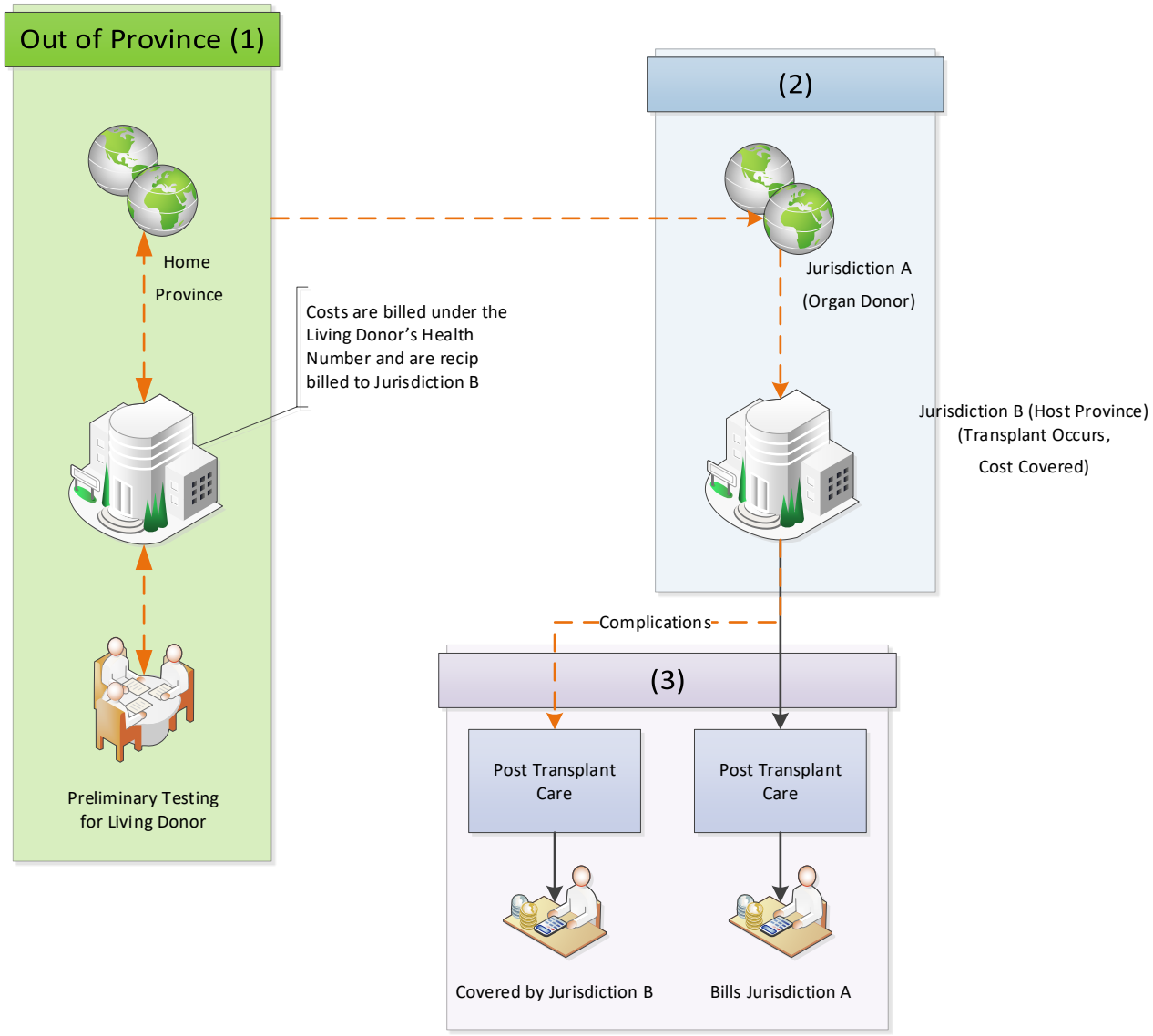
This policy applies to the block rates for Bone Marrow/Stem Cell transplants only. If the patient is admitted prior to or after the transplant under a separate admission/discharge, then the jurisdiction responsible for coverage on those days is responsible for payment of the separate in-patient stay.

6.12 Out of Province/Country Living Donor Costs

Out-of-Province/Territory Living Donor

Blood testing markers and other tests to determine if the donor is a match are typically done to determine compatibility. These tests should be done on a living donor before they arrive at the host jurisdiction.

Scenario and rules for living donor in jurisdiction A traveling to transplant recipient's home province jurisdiction B where transplant occurs:

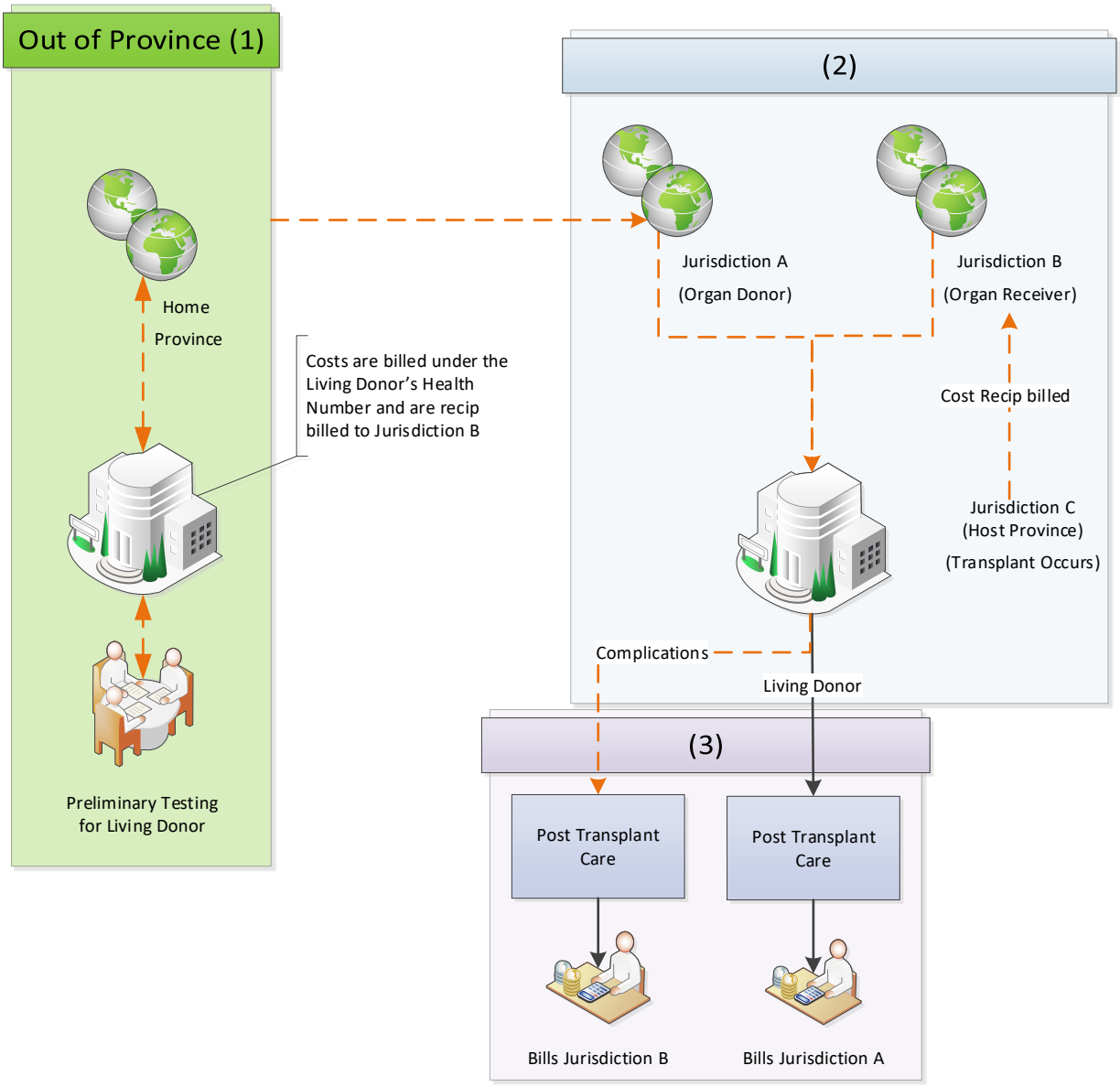


1) Living donor in jurisdiction A undergoes testing in jurisdiction A to determine compatibility.
- Costs are billed reciprocally under the transplant recipient's health number by jurisdiction A to jurisdiction B.

2) Living donor arrives in jurisdiction B. Further testing occurs, the organ is harvested, and the organ transplant occurs.
- All costs are the responsibility of jurisdiction B.

3) Other pre or post donor transplant care.
- Emergency post-transplant care services related to complications arising from the transplant are covered by jurisdiction B. Emergency services **not** related to the transplant are reciprocally billed under the donor's health number by jurisdiction B to jurisdiction A.

Scenario and rules for living donor from jurisdiction A and recipient from jurisdiction B travelling to jurisdiction C for the transplant:



1) Living donor in jurisdiction A undergoes testing in jurisdiction A to determine compatibility.
- These costs are billed reciprocally under the transplant recipient's health number by jurisdiction A to jurisdiction B.

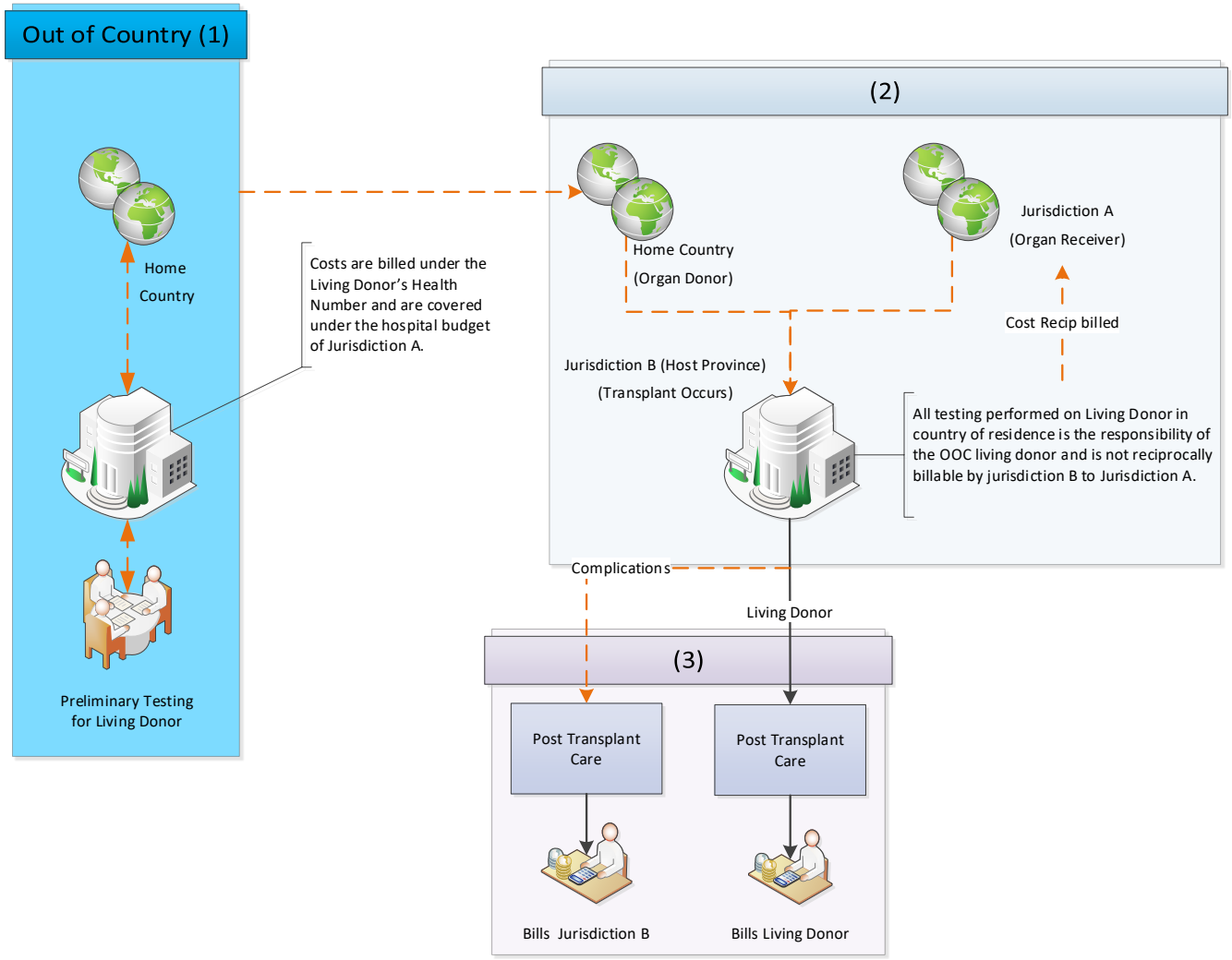
2) Living donor and recipient arrive in jurisdiction C. Further testing occurs, the organ is harvested, and the organ transplant occurs
- All costs are billed reciprocally using code 99 under the transplant recipient's health number by jurisdiction C to jurisdiction B.

3) Other pre or post donor transplant care.
- Emergency post-transplant care services related to complications arising from the transplant are billed under the recipient's health number by jurisdiction C to jurisdiction B. Emergency services **not** related to the transplant are reciprocally billed under the donors health number by jurisdiction C to jurisdiction A.

Out-of-Country Living Donor

Preliminary testing for an out-of-country living donor is done in the donor's home country before they arrive in the jurisdiction where the transplant will occur.

Scenario and rules for an out-of-country living donor and Canadian transplant recipient from jurisdiction A travelling to the host jurisdiction B for the transplant:



1) Living donor preliminary testing is performed in the country of origin and donor travels to jurisdiction B for transplant.
- Any costs incurred by jurisdiction B are documented by jurisdiction B and later billed to jurisdiction A.

2) Living donor and recipient arrive in jurisdiction B. Further testing occurs, the organ is harvested, and the organ transplant occurs.
- All costs, including preliminary testing are billed reciprocally using code 100 under the transplant recipient's health number by jurisdiction B to jurisdiction A.

3) Other pre or post-transplant care.
- Emergency post-transplant care services related to complications arising from the transplant are billed under the recipient's health number by jurisdiction B to jurisdiction A. Emergency services **not** related to the transplant are the responsibility of the donor.

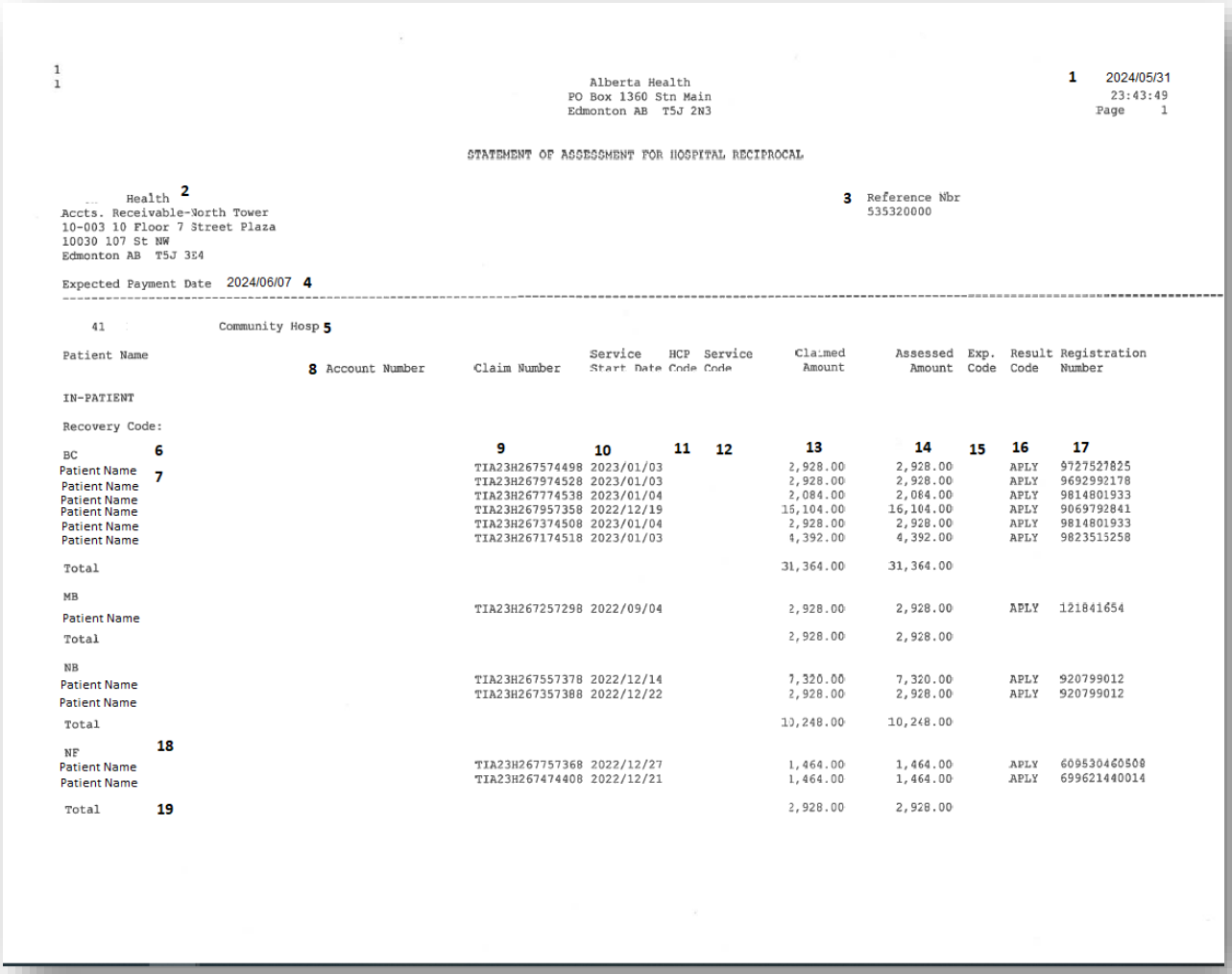
7.0 Processing and Payment of Claims

The hospital reciprocal claims processing system is designed to process and pay claims weekly. Two reports are issued weekly to Alberta Health Services Accounts Receivable to provide information about the claims that were processed during the period:

Statement of Assessment
This report contains details of claims that were approved for payment, reduced in payment, or refused. It also displays any adjustments made to previously paid claims. The information is organized by hospital number, patient type (in-patient, outpatient) and recovery code. A summary page shows the in-patient and outpatient totals for each province/territory.

Statement of Account
This report is issued in conjunction with the Statement of Assessment. It reports the total amount being paid for claims and adjustments (if applicable) detailed on the associated Statement(s) of Assessment. The information is organized by hospital number, hospital name, patient type (in-patient or outpatient) and amount paid per hospital.

7.1 Statement of Assessment – Sample



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Alberta Health
PO Box 1360 Stn Main
Edmonton AB T5J 2N3

1 2024/05/31
23:43:49
Page 1

STATEMENT OF ASSESSMENT FOR HOSPITAL RECIPROCAL

... Health 2
Accts. Receivable-North Tower
10-003 10 Floor 7 Street Plaza
10030 107 St NW
Edmonton AB T5J 3E4

3 Reference Nbr
535320000

Expected Payment Date 2024/06/07 4

41 Community Hosp 5

Patient Name	8 Account Number	Claim Number	Service Start Date	HCP Code	Service Code	Claimed Amount	Assessed Amount	Exp. Code	Result Code	Registration Number
IN-PATIENT										
Recovery Code:										
BC 6		9	10	11	12	13	14	15	16	17
Patient Name 7		TIA23H267574498	2023/01/03			2,928.00	2,928.00		APLY	9727527825
Patient Name		TIA23H267974528	2023/01/03			2,928.00	2,928.00		APLY	9692992178
Patient Name		TIA23H267774538	2023/01/04			2,084.00	2,084.00		APLY	9814801933
Patient Name		TIA23H267957358	2022/12/19			16,104.00	16,104.00		APLY	9069792841
Patient Name		TIA23H267374508	2023/01/04			2,928.00	2,928.00		APLY	9814801933
Patient Name		TIA23H267174518	2023/01/03			4,392.00	4,392.00		APLY	9823515258
Total						31,364.00	31,364.00			
MB										
Patient Name		TIA23H267257298	2022/09/04			2,928.00	2,928.00		APLY	121841654
Total						2,928.00	2,928.00			
NB										
Patient Name		TIA23H267557378	2022/12/14			7,320.00	7,320.00		APLY	920799012
Patient Name		TIA23H267357388	2022/12/22			2,928.00	2,928.00		APLY	920799012
Total						10,248.00	10,248.00			
NF 18										
Patient Name		TIA23H267757368	2022/12/27			1,464.00	1,464.00		APLY	609530460508
Patient Name		TIA23H267474408	2022/12/21			1,464.00	1,464.00		APLY	699621440014
Total 19						2,928.00	2,928.00			

7.2 Statement of Assessment – Field Descriptions

1. **Statement date —** Date on which the statement was produced.
2. **Statement of Assessment addressee —** Name and address of the organization designated to receive the Statement.
3. **Reference number —** Unique ID number assigned to each Statement of Assessment.
4. **Expected payment date —** Date on which payment is expected to be issued.
5. **Hospital number and name —** Hospital that provided the health care service.
6. **Recovery code —** Code identifying the province/territory where the patient has coverage.
7. **Patient name —** Patient's last name and first name.
8. **Account number —** For internal hospital use only. Account number is not required by Alberta Health.
9. **Claim number —** Unique ID number assigned to each claim by Alberta Health when it is processed. This number is required on any subsequent correspondence to Alberta Health regarding that claim.
10. **Service start date —** Date the service was performed or admission date, as applicable.
11. **HCP code —** High cost procedure code, if applicable.
12. **Service code —** Code describing the service provided, if applicable.
13. **Claimed amount —** Amount claimed for the service provided.
14. **Assessed amount —** Amount to be paid for the service.

If the assessed amount is "0.00" and the result code field displays APLY, assessment has determined that payment is not warranted, and the claim has been "paid at zero". Paid at zero does not mean the claim has been "refused". See the result code field explanation for a definition of a refused claim.

If the assessed amount field displays a negative amount (e.g., 361.00–), this indicates that a previously paid claim has been reversed due to an adjustment.

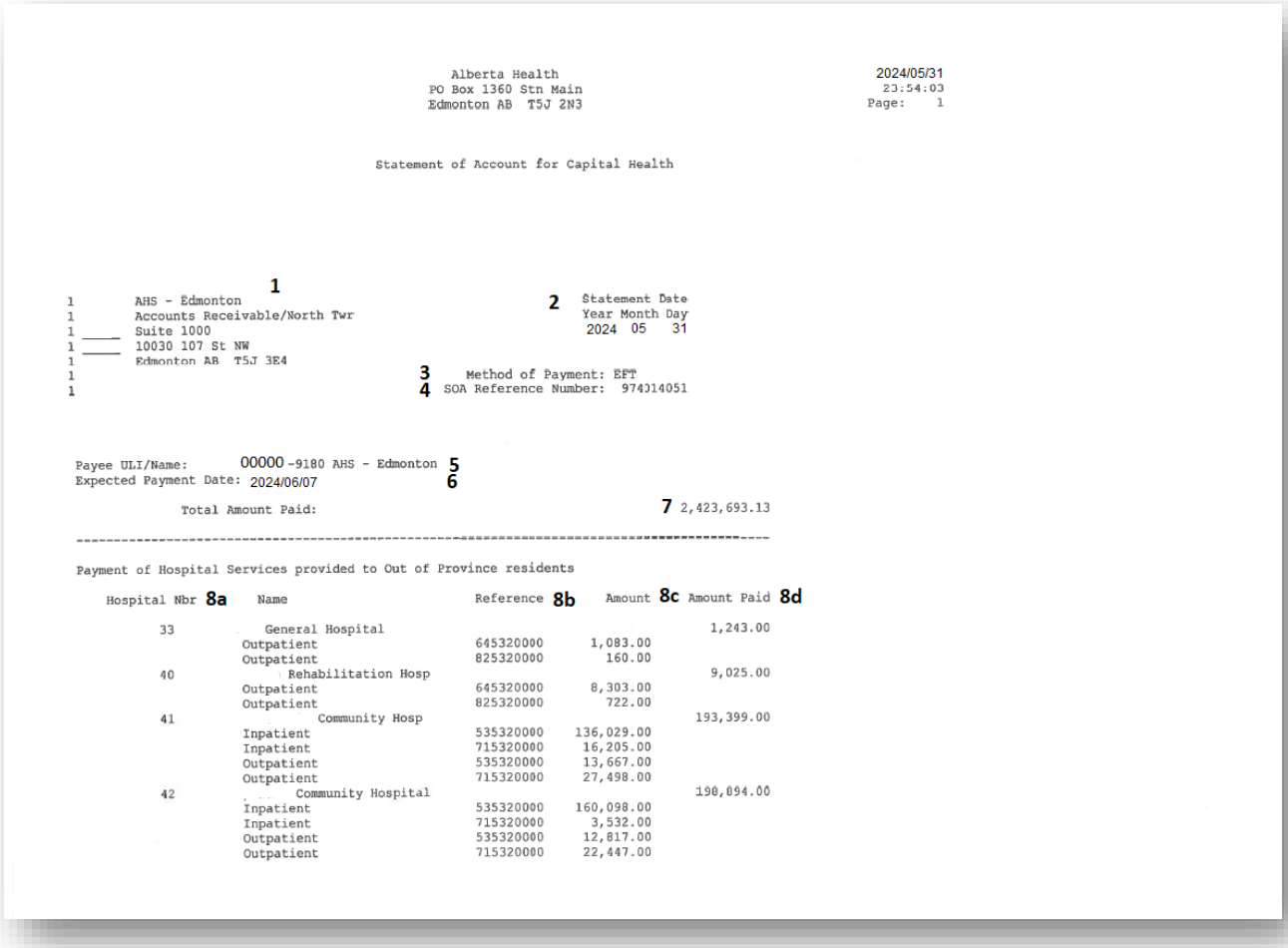
15. **Explanatory code —** Two or three digit code indicating why a claim has been paid at zero, reduced or refused, if applicable (Appendix C - Statement of Assessment Explanatory Codes). Only one explanatory code can be displayed on the statement; if there are multiple explanatory codes you will need to contact the Hospital Reciprocal Billing Unit for more information.

16. **Result code —** Codes explaining the results of processing a claim are:
    APLY (applied) **–** The claim has been processed and assessment is complete. An applied claim may be paid in full, reduced in payment, or paid at zero.
    RFSE (refused) **–** Assessment criteria **could not be applied** because essential information was missing or incorrect so the claim has been refused. If appropriate, refused claims should be corrected and resubmitted as a new claim. (Section 8.1 – Resubmitting a Refused (RFSE) Claim).

> If a claim has been refused several times, contact the Hospital Reciprocal unit for assistance at HMR.Unit@gov.ab.ca.

17. **Registration number —** Patient's out-of-province registration number.
18. **Total —** Total amount claimed and paid for the hospital's in-patient services.
19. **Total —** Total amount claimed and paid for the hospital's outpatient services.
20. **Summary —** Summary totals by province/territory and patient type.

7.3 Statement of Account – Sample



Alberta Health
PO Box 1360 Stn Main
Edmonton AB T5J 2N3

2024/05/31
23:54:03
Page: 1

Statement of Account for Capital Health

1
1 AHS - Edmonton
1 Accounts Receivable/North Twr
1 Suite 1000
1 10030 107 St NW
1 Edmonton AB T5J 3E4
1
1

2 Statement Date
Year Month Day
2024 05 31

3 Method of Payment: EFT
4 SOA Reference Number: 974014051

Payee ULI/Name: 00000 -9180 AHS - Edmonton 5
Expected Payment Date: 2024/06/07 6

Total Amount Paid: 7 2,423,693.13

Payment of Hospital Services provided to Out of Province residents

Hospital Nbr 8a	Name	Reference 8b	Amount 8c	Amount Paid 8d
33	General Hospital			1,243.00
	Outpatient	645320000	1,083.00	
	Outpatient	825320000	160.00	
40	Rehabilitation Hosp			9,025.00
	Outpatient	645320000	8,303.00	
	Outpatient	825320000	722.00	
41	Community Hosp			193,399.00
	Inpatient	535320000	136,029.00	
	Inpatient	715320000	16,205.00	
	Outpatient	535320000	13,667.00	
	Outpatient	715320000	27,498.00	
42	Community Hospital			198,894.00
	Inpatient	535320000	160,098.00	
	Inpatient	715320000	3,532.00	
	Outpatient	535320000	12,817.00	
	Outpatient	715320000	22,447.00	

7.4 Statement of Account – Field Descriptions

1. **Statement of Account addressee —** Name and address of the organization designated to receive this statement.
2. **Statement date —** Date on which this statement information was produced.
3. **Method of payment —** Means by which the payment will be made. Alberta Health makes hospital reciprocal payments by electronic funds transfer (EFT).
4. **SOA reference number —** Unique ID number assigned to each Statement of Account.
5. **Payee ULI/name —** Unique lifetime identifier (ULI) and the name of the payment recipient.
6. **Expected payment date —** Date on which payment is expected to be issued.
7. **Total amount paid —** Total amount paid to the organization on this Statement of Account.
8. **Payment summary —** This section has four components:
    - **8a. Hospital number, name —** Hospital(s) listed on the Statement(s) of Assessment associated with this Statement of Account.
    - **8b. Reference —** Reference number(s) of the Statement(s) of Assessment associated with this Statement of Account.
    - **8c. Amount —** Amount paid per hospital per patient type on the associated Statement(s) of Assessment.
    - **8d. Amount paid —** Amount paid per hospital on the associated Statement(s) of Assessment.

8.0 Resubmissions and Adjustments

While reviewing your Alberta Health Statement of Assessment, you may notice that a claim (whether paid in full, at a reduced rate or at zero) was processed with incorrect information or should not have been submitted at all. This section describes the action to take when you need to follow up on a processed claim.

An explanatory code will show on the Statement of Assessment to indicate the reason the claim was paid at zero, reduced, refused, or adjusted (Appendix C – Statement of Assessment Explanatory Codes).

8.1 Resubmitting a Refused (RFSE) Claim

If a claim displays result code **RFSE**, it means the claim transaction was refused. This is usually due to invalid or missing claim data. If a refused claim needs to be resubmitted for payment, the claim details must be corrected and sent as a **new claim**. The new, corrected claim is now considered the **initial submission** for the service. When the new, corrected claim is processed, the result is reported on a Statement of Assessment with a **new claim number**.

8.2 Resubmitting an Applied (APLY) Claim

A claim displaying result code **APLY** was either paid in full, or paid at a reduced rate, or paid at zero. In each case, if an applied claim contains incorrect information, it can be resubmitted.

For paper submissions, follow the steps below to reverse the original submission and replace it with a corrected claim.

For electronic claims submissions, an adjustment for a negative amount cannot be submitted. These requests must be faxed to the HMR Unit.

1. Resubmit the previously processed claim, with all data elements **identical** to the original submission. Enter a **minus sign (–)** to the left of the amount to be recovered (e.g., –337.00) in the "Claimed Amount" or "Total" field, as applicable to the claim form. When processed, the negative amount will appear on the Statement of Assessment.

(**Optional:** Along with the claim details, you can also enter the claim number of the original submission in the "Adjustment Claim Number" field, as it appeared on the Statement of Assessment).

2. Submit a new claim with all mandatory fields completed, **including the corrected data.** This replaces the previous submission that was reversed at step one and will appear on the Statement of Assessment with a new claim number.

To initiate recovery of an applied claim that should not have been submitted in the first place and is not being replaced by a new claim, follow step one only.

Claim resubmissions must be received by Alberta Health **within 10 months** after the patient's date of service/date of discharge. (Section 3.2 - Time Limit Guidelines).

8.3 Adjustments Requested by the Patient's Home Province/Territory

Out-of-province claims are paid as billed. Any required adjustments due to errors, omissions or patient eligibility can be generated by a request from the out-of-province patient's home health care plan.

There are a number of reasons an adjustment may be requested, including:

- Patient eligibility,
- Missing/invalid data on claims submission,
- Missing patient's out-of-province address,
- Incomplete/missing Declaration of Hospital Coverage form,
- Incorrect application of IHIACC-approved reciprocal billing rules and rates, or
- Duplicate in-patient or outpatient submissions.

For example, if the home province/territory determines that a patient's health care number was not in effect on the date a service was provided and for which a claim was paid to an Alberta hospital, they can ask Alberta Health to recover the payment. If Alberta Health grants the request, an adjustment appears on the Statement of Assessment to the hospital.

If the previous payment is being recovered, the full amount and two claim lines appear on the Statement:

- the first line contains the details of the previously paid claim, with a negative amount (e.g., $440.00–) in the Assessed Amount field and RVRSL in the Explanatory Code field.
- the second line contains the claim details, with 0.00 in the Assessed Amount field and an explanatory code to indicate the reason for the recovery (Appendix C - Statement of Assessment Explanatory Codes).

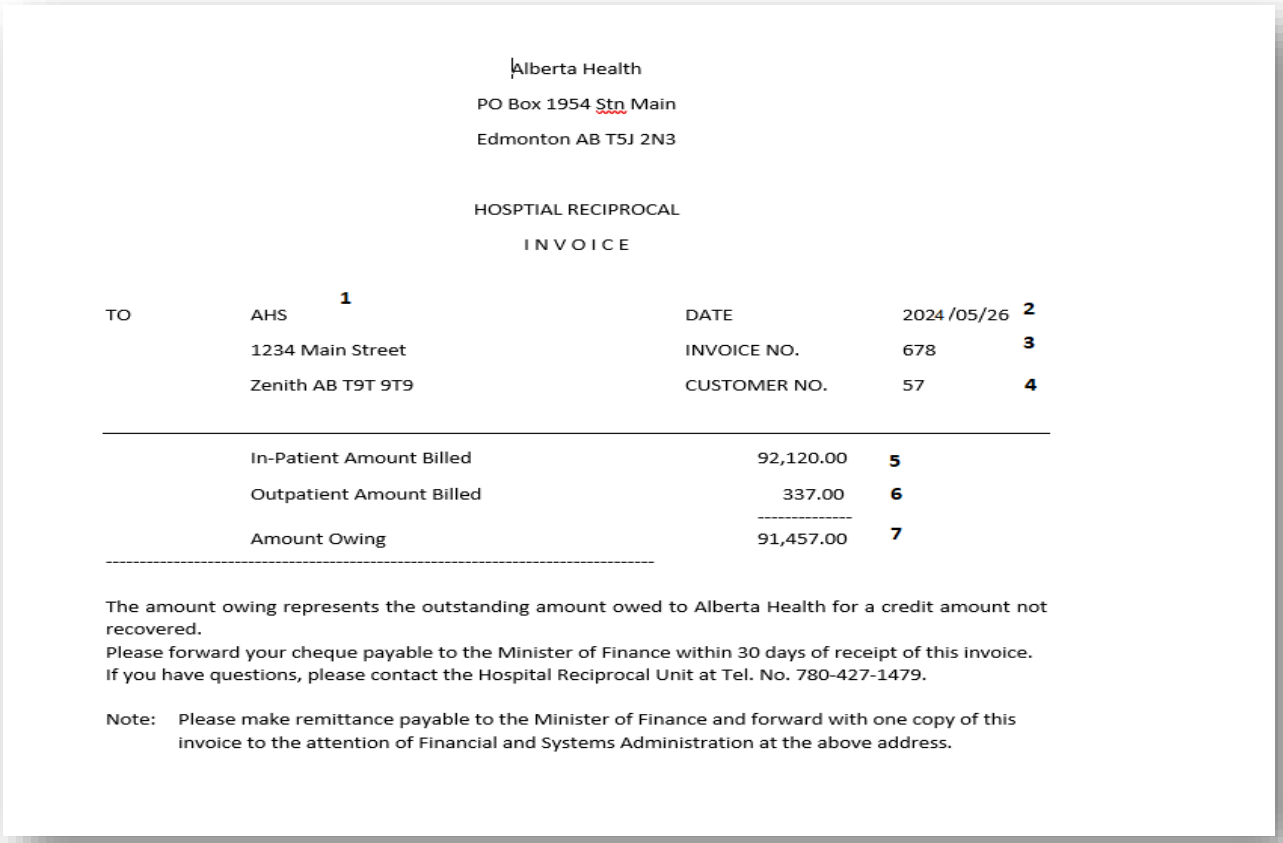
Provinces/territories have 18 months from the discharge date (for in-patient services) or service date (for outpatient services) to request an adjustment from Alberta Health.

8.4 Hospital Reciprocal Invoice to Recover Claims Payments

There may be rare instances when adjustments to recover previous Alberta Health payments cannot be completed on the Statement of Assessment. This would occur when the amount to be paid for new, incoming claims is less than the amount owed by the hospital for the recovered claim(s).

This negative amount will clear within two to three weeks when the next hospital submissions are sent to Alberta Health. In this case, Alberta Health produces a Hospital Reciprocal Invoice to the hospital and a Hospital Reciprocal Region Invoice Details report, to request a refund of the balance owing.

8.5 Hospital Reciprocal Invoice - Sample



Alberta Health
PO Box 1954 Stn Main
Edmonton AB T5J 2N3

HOSPTIAL RECIPROCAL
INVOICE

TO	AHS **1**	DATE	2024 /05/26	**2**
	1234 Main Street	INVOICE NO.	678	**3**
	Zenith AB T9T 9T9	CUSTOMER NO.	57	**4**

In-Patient Amount Billed	92,120.00	**5**
Outpatient Amount Billed	337.00	**6**
Amount Owing	91,457.00	**7**

The amount owing represents the outstanding amount owed to Alberta Health for a credit amount not recovered.
Please forward your cheque payable to the Minister of Finance within 30 days of receipt of this invoice.
If you have questions, please contact the Hospital Reciprocal Unit at Tel. No. 780-427-1479.

Note: Please make remittance payable to the Minister of Finance and forward with one copy of this invoice to the attention of Financial and Systems Administration at the above address.

8.6 Hospital Reciprocal Invoice – Field Descriptions

1. **Invoice addressee —** Name and address of the organization designated to receive the invoice.
2. **Date —** Date the invoice was generated.
3. **Invoice number —** ID number of the invoice.
4. **Customer number —** For Alberta Health use only.
5. **In-patient amount billed —** Dollar amount invoiced for in-patient services.
6. **Outpatient amount billed —** Dollar amount invoiced for outpatient services.
7. **Amount owing —** Total amount owing.

APPENDICES

Appendix A – Contact Information

A.1 Alberta Health Contact Information

If you cannot find the information you need in this claim submission guide, contact the Hospital Reciprocal Billing Unit. Office hours are Monday to Friday, 8:15 a.m. to 4:30 p.m. (except for government holidays).

Email Address: HMR.Unit@gov.ab.ca.

Mailing address

Hospital reciprocal claims and related correspondence can be mailed to:

Hospital Reciprocal Billing Unit
Alberta Health
PO Box 1360 Stn Main
Edmonton AB T5J 2N3

A.2 Obtaining Alberta Health Forms

In-patient and outpatient claim forms, summary statement forms and hospital insurance coverage declaration forms can be found online at:

http://www.alberta.ca/health-professional-business-forms.aspx

A.3 Provincial/Territorial Hospital Reciprocal Billing Contacts

British Columbia
Ministry of Health
Out-of-Province Claims
2-1, 1515 Blanshard Street
Victoria, BC V8W 3C8
Telephone: 250-952-1334
Fax: 250-952-1940
Email: HLTH.Oopclaims@gov.bc.ca

Manitoba
Manitoba Health
Hospital Abstract/Reciprocal Billing
300 Carlton Street
Winnipeg, MB R3B 3M9
Telephone: 204-786-7380 or 204-786-7303
Fax: 204-772-2248
Email: OutofProvinceClaims@gov.mb.ca

New Brunswick
New Brunswick Medicare
Eligibility and Claims
520 King Street, 4th Floor
Fredericton, NB E3B 6G3
Telephone: 506-453-4045
Fax: 506-457-3547

Newfoundland and Labrador
Medical Care Plan
Dept of Health & Community Services
P.O. Box 5000, 22 High Street
Grand Falls – Windsor, NL
A2A 2Y4
Telephone: 709-729-5222
Fax: 709-729-1918

Northwest Territories
Manager of Health Care Eligibility and Insurance Programs
Health Services Administration
Bag Service #9
Inuvik, NT X0E 0T0
Toll Free: 1-800-661-0830 Ext. 161
Fax: 867-777-3197
Email: hsa@gov.nt.ca

Nova Scotia
Nova Scotia Department of Health & Wellness
Benefits Eligibility,1894 Barrington ST , 12th Floor
Barrington Tower
PO Box 488
Halifax, NS B3J 2R8
Telephone: 902-424-7538
Fax: 902-424-2198

Nunavut
Health Insurance Programs
Box 889, Rankin Inlet, NU
X0C 0G0
Phone: 867-645-8002
Fax: 867-645-8092

Ontario
Ministry of Health and Long-Term Care Health-Health Services Branch
1055 Princess St
Kingston, Ontario K7L 1H3
E-mail: InterprovinceBilling.MOH@ontario.ca.
Fax: 613-900-0536

Prince Edward Island
Out-of-Province Coordinator
Medical Affairs
PO Box 2000
16 Garfield Street
Charlottetown, PE C1A 7N8
Telephone: 902-368-6516
Fax: 902-569-0581
Verify Registration numbers:
Telephone: 902-838-0918
Fax: 902- 838-0940

Québec
Regie de l'assurance-maladie du Quebec
CP 6600 Dépôt Q022
Quebec, QC G1K 7T3
Telephone: 418-643-8114
Fax: 418-643-6166

Saskatchewan
Saskatchewan Ministry of Health
Medical Services Branch
Claims Analysis Unit
3475 Albert Street
Regina, SK S4S 6X6
Telephone 306-787-3439
Eligibility Confirmation:
Telephone: 306-787-3475, Press #3 when prompted.
Fax: 306-798-0582

Yukon Territory
Insured Health and Hearing Branch
Department of Health & Social Services
Government of Yukon
H-2 Box 2703
Whitehorse, YT Y1A 2C6
Telephone: 867-667-5209
Registration inquiries 867-667-5271
Fax: 867-393-6486

A.4 Provincial/Territorial General Inquiries

British Columbia
Health Insurance BC Medical Services Plan
Telephone: 604-683-7151
Outside BC: 1-800-663-7100
E-mail: mspenquiries@hibc.gov.bc.ca
Website:
http://www2.gov.bc.ca/gov/content/health/health-drug-coverage/msp/bc-residents-contact-us

Manitoba
General Inquiries Line: 204-786-7101
Toll free in North America: 1-800-392-1207
Email: insuredben@gov.mb.ca
Website: www.manitoba.ca/health/mhsip

New Brunswick
Main Line: 506-453-8275
Outside the province: 1-506-684-7901
E-mail: http://www.gnb.ca/0051/mail-e.asp
Website:
http://www2.gnb.ca/content/gnb/en/departments/health/contacts/dept_renderer.141.html#contacts

Newfoundland and Labrador
Medical Care Plan (MCP)
Avalon Region:
Toll-Free 1-866-449-4459
Tel: 709-758-1500
All other areas, Including Labrador:
Toll-Free 1-800-563-1557
Tel: 709-292-4027
E-mail: healthinfo@gov.nl.ca
Website:
http://www.health.gov.nl.ca/health/index.html

Northwest Territories
Registrar General, Health Services Administration
Telephone: 1-800-661-0830
E-mail: healthcarecard@gov.nt.ca
Website: www.hss.gov.nt.ca/contact-us

Nova Scotia
Nova Scotia Medical Services Insurance (MSI)
General Inquiries: 902-496-7008
E-mail: MSI@medavie.ca
Website: http://novascotia.ca/dhw/msi/contact.asp

Nunavut
Telephone: 867-645-8001
Toll free (throughout Canada): 1-800-661-0833
E-mail: nhip@gov.nu.ca
Website: http://gov.nu.ca/health/information/nunavut-health-care-plan

Ontario
Service Ontario, Infoline: 1-866-532-3161 TTY: 1-800-387-5559
Website:
https://www.ontario.ca/page/apply-ohip-and-get-health-card

Note: Service Ontario does not release Ontario health numbers. Refer to Section A.3 for additional information.

Prince Edward Island
PEI General Inquiry: 902-368-6414
Toll free (throughout Canada): 1-800-321-5492
E-mail: healthweb@gov.pe.ca
Website:
https://www.princeedwardisland.ca/en/topic/health-and- wellness

Québec
Service de l'évolution des processus
Régie de l'assurance maladie du Québec
Québec City: 418 646-4636
Montréal: 514-864-3411
Website: http://www.ramq.gouv.qc.ca/en/contact-us/citizens/Pages/contact-us.aspx

Saskatchewan
Saskatchewan Health Registration: 306-787-3251
Toll free within the province: 1-800-667-7551, press #6
E-mail: info@health.gov.sk.ca
Website:
https://www.ehealthsask.ca/Pages/default.aspx

Yukon Territory
Health Care Insurance Plan
Telephone: 867-667-5209
Toll Free within the Territory: 1-800-661-0408 ext. 5209
E-mail: hss@gov.yk.ca
Website: http://www.hss.gov.yk.ca/contactus.php

Appendix B – Health Cards

B.1 Provincial/Territorial Codes and Health Card Information

The table below provides a summary of the province/territory codes, health card number formats and requirements for entering an out-of-province patient's health card expiry date on a hospital reciprocal claim. A health card with a year and month expiry date (e.g., 2022/12) is valid until the end of the month shown on the card, unless otherwise determined by the health care plan of the patient's province/territory of residence.

Province/Territory	Province Code	Health Number Format	Health Card Expiry Date Field Requirements
Alberta	AB	9 numeric	Blank (no expiry date on card) or YYYYMMDD
British Columbia	BC	10 numeric	Blank if no expiry date on card, or YYYYMMMDD if expiry date shown on card
Manitoba	MB	9 numeric	Blank (no expiry date on card)
New Brunswick	NB	9 numeric	MMYYYY (partial date only on card)
Newfoundland and Labrador	NL	12 numeric	YYYYMMDD
Northwest Territories	NT	1 alpha character followed by 7 numeric (8 characters in total)	DDMMYYYY
Nova Scotia	NS	10 numeric	YYYYMMMDD
Nunavut	NU	9 numeric	DDMMYYYY
Ontario	ON	10 numeric characters The Ontario photo health card has 10 numeric characters followed by 1 or 2 alpha characters for the version code. The version code should not be keyed for reciprocal billing purposes.	Blank if no expiry date on card, or YYYYMMDD if expiry date shown on card
Prince Edward Island	PE	8 numeric	YYYYMM (partial date only on card) or YYYYMMDD
Quebec	PQ	4 alpha characters followed by 8 numeric (12 characters in total)	YYYYMM (partial date only on card)
Saskatchewan	SK	9 numeric	MMYYYY (partial date only on card)
Yukon	YT	9 numeric	YYMMDD

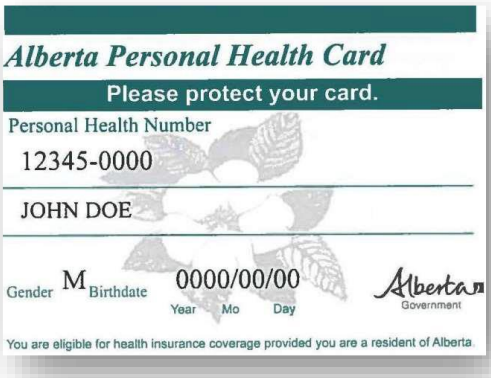
B.2 Valid Provincial/Territorial Health Cards

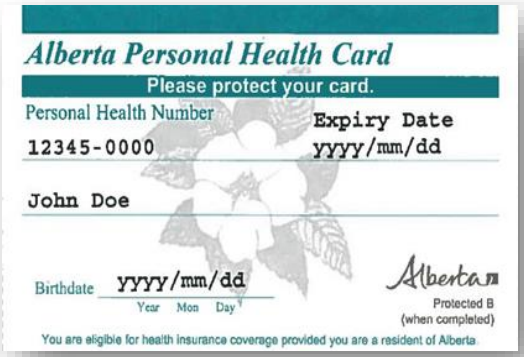
Alberta Health does not provide copies of the Provincial/Territorial Health Care Card Poster. As revised versions of the poster are released by Health Canada, they are posted on the Alberta Health website at

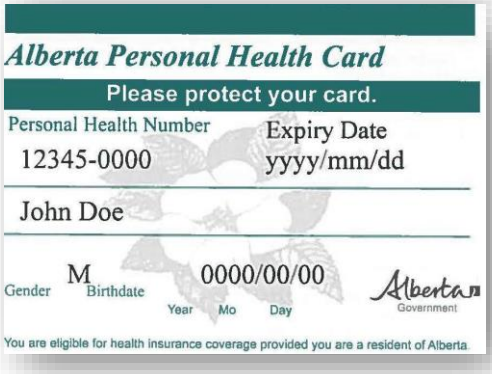
www.alberta.ca/health-professional-business-forms.aspx

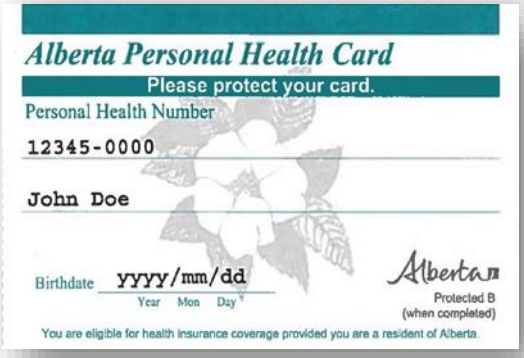
ALBERTA

- Alberta personal health cards are not issued annually. New residents and newborns are issued cards when they are registered. Replacement cards are issued upon request.
- Information on the card includes the individual's nine-digit personal health number (PHN), name, gender, and date of birth.
- Personal Health Cards issued to permanent residents do not have an expiry date.
- Personal Health Cards issued to temporary residents such as foreign workers, students and their dependents have an expiry date.

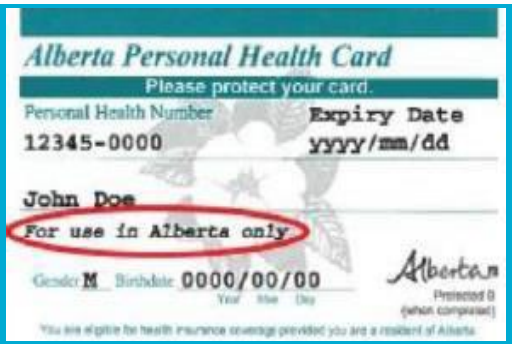








Alberta issues a health card to persons eligible for benefits under Alberta's Ukrainian Evacuee Temporary Health Benefits Program. This card is valid only in the province of Alberta and cannot be used for Reciprocal Billing.

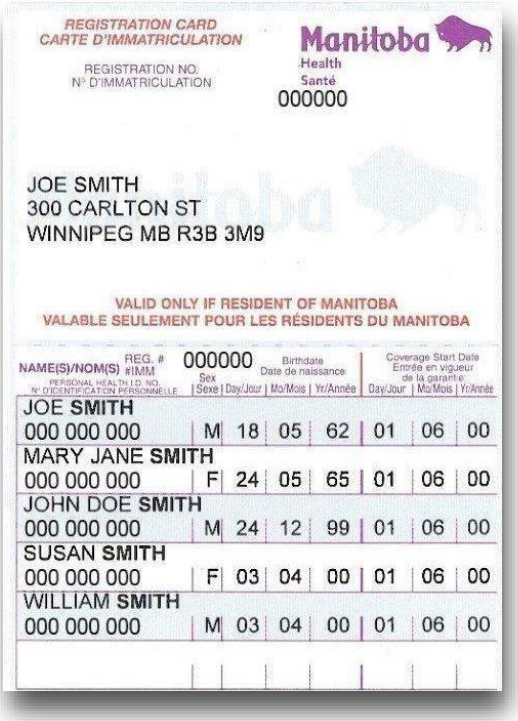


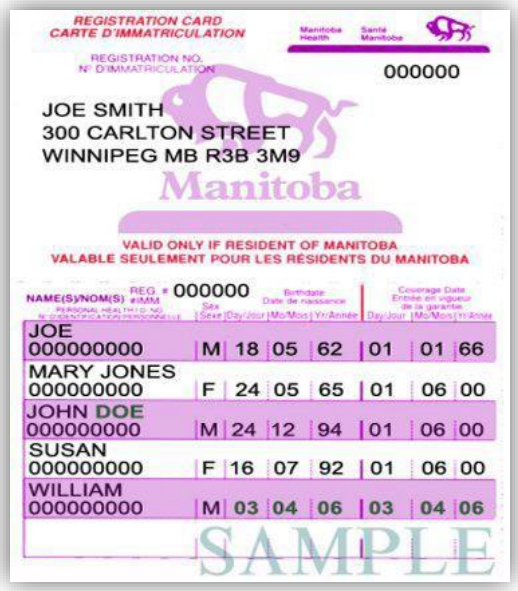
BRITISH COLUMBIA

- BC Service Card may act as both a Healthcare Card (access to publicly funded health services through the Medical Service Plan (MSP)) and/or a Drivers ID/Photo ID.
- Some BC residents may have a non-photo BC Services card. These residents include: children and youth under 19, adults with temporary immigration status, adults 75 and older. Additional Information can be found on the BC website: https://www2.gov.bc.ca/gov/content/governments/government-id/bc-services-card.

MANITOBA

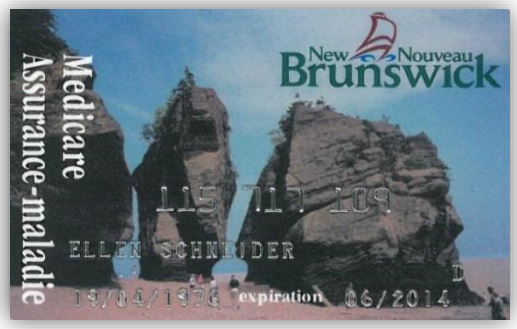
- Manitoba Health issues a card (or registration certificate) to all Manitoba residents.
- It includes a 9-digit lifetime identification number for each family member.
- The white paper card has purple and red print and includes the previous 6-digit family or single person's registration number, name and address of Manitoba resident, family member's given name and alternate (if applicable), sex, birth date, effective date of coverage, and 9-digit Personal Health Identification Number (PHIN).

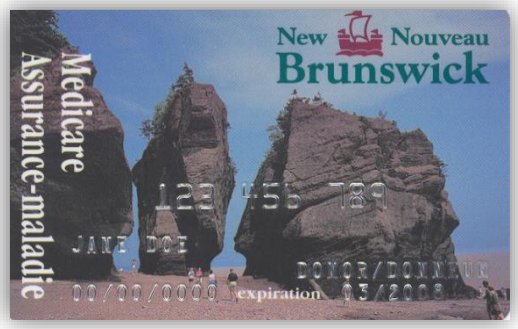




NEW BRUNSWICK

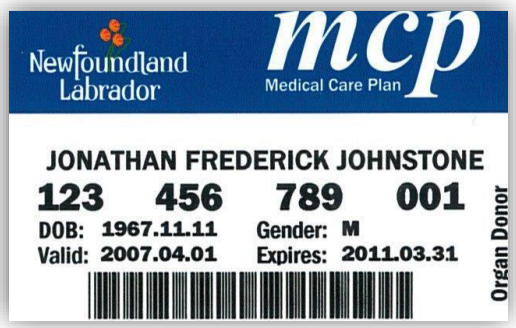
- The plastic card with a magnetic strip depicts a New Brunswick scene of the Flowerpot Rocks-Hopewell Cape.
- The New Brunswick logo is displayed in the upper right corner.
- The card contains the 9-digit Medicare registration number, the subscriber's name, date of birth and expiry date of the card.





NEW FOUNDLAND AND LABRADOR

- The MCP cards contain an individual's name, gender, MCP number and birth date.
- The cards have an expiry date to allow the Department of Health and Community Services to periodically update the MCP database and provide an improved mechanism for accountability.
- Effective November 1, 2017, barcodes have been added to newly issued MCP cards to enable a beneficiary to self- register for scheduled appointments at health care facilities throughout the province.

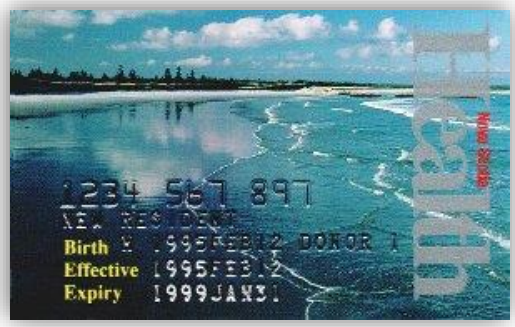


NORTHWEST TERRITORIES

- The NWT health care card shows the new visual elements of the Government of the NWT.
- The card includes the insured person's health insurance number, name, and the expiry date of the card.

NOVA SCOTIA

- Nova Scotia's health card is made of plastic and features a beachscape with clouds in the distance against a blue background.
- The words Nova Scotia (red) and Health (silver) are printed along the right edge.
- The card includes the insured person's ten-digit health insurance number, name, gender and date of birth; the effective date of coverage; and the expiry date of the card. All dates are yyyy/mmm/dd. The numbers and letters are embossed and tipped with silver foil.

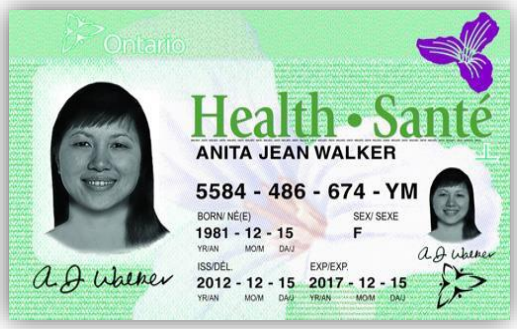


NUNAVUT

- The Nunavut health card is made of pale grey plastic.
- It features a territorial map of Canada, in red, on which Nunavut is shown in dark grey. A circle is superimposed around the Territory, with the words NUNAVUT CANADA in three languages.
- In the upper portion of the card the word NUNAVUT appears in pale grey, with the word HEALTH superimposed in four languages.
- The card shows the following information: the nine-digit health insurance number, name, and date of birth of the insured person, the address and telephone number of the Nunavut administrative services, the signature of the cardholder, as well as the card's expiry date.

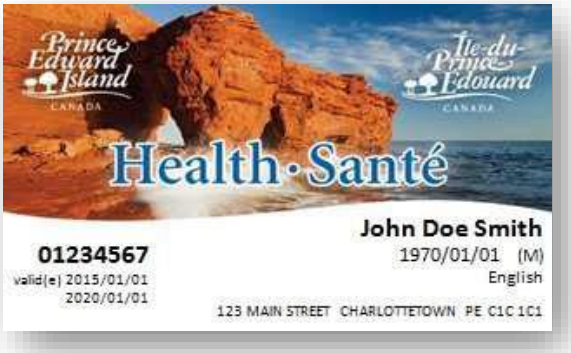
ONTARIO

- Both the red and white and the current photo health card remain acceptable as proof of entitlement to medically necessary insured health services, provided they are valid and belong to the person presenting the card.
- The red and white health card shows the Personal Health Number and name.
- The photo health card contains a Personal Health Number, name, effective date for coverage, termination date for coverage, sex, and the beneficiary's month and year of birth.
- Cards must be signed. Red and white cards are signed on the back, while the photo card is signed on the front.
- Children under the age of 15 ½ years have health cards that are exempt from both photo and signature.



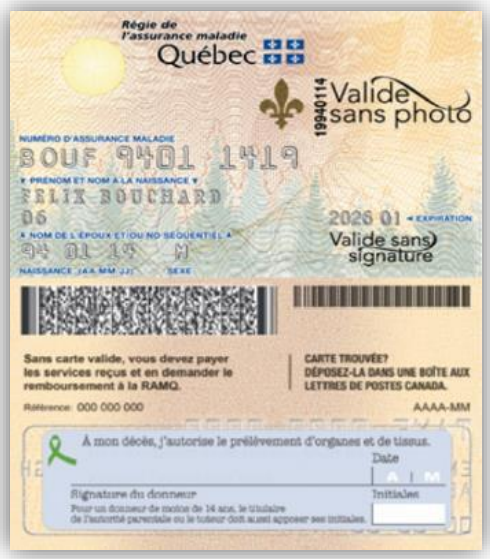
PRINCE EDWARD ISLAND

- A new bilingual health care card for PEI came into effect in February 2016 showing a design that prominently features the stunning Darnley shoreline.
- The new card will feature on the front the individual's preferred language of service. The back of the card may include a red heart which shows the owner's intention to be an organ donor.
- The orange health card will be phased out over the next five years as the existing cards expire. Health PEI and other government and non-government organizations will continue to accept the orange health card as long as it is valid.
- Both cards show a unique 8-digit lifetime identification number, the given name(s), birth date and gender of the resident, as well as the expiry date of the health card.



QUEBEC

- The Régie issues a Health Insurance Card to persons eligible for the Québec Health Insurance Plan.
- The resident's photograph and signature are both digitized and incorporated into the card. Cards issued to persons not required to provide a photo and a signature, such as children under age 14, have no photo or signature spaces, while cards issued to persons exempt from providing their photo, their signature or both, are marked "exempté" in the appropriate space(s)
- Information appearing on the Health Insurance Card include: resident's first and last name, birth date and gender of the resident, as well as the expiry date (year and month).
- All cards are valid until the last day of the month in which they expire.

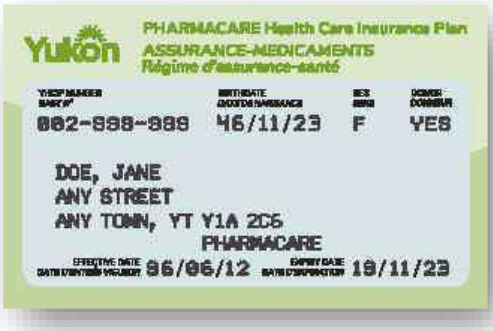


SASKATCHEWAN

- The plastic cards are blue above and grey below a green, yellow and white stripe.
- Cards contain a Personal Health Number, name, effective date for coverage, termination date for coverage, sex, beneficiary's month and year of birth and 8-digit Family/Beneficiary number.

YUKON

- The newer style Pharmacare card is a light green with a medium green logo and text. The label affixed to both cards is the same style and colour.
- A green health care card is issued to Yukon senior citizens registered with the Pharmacare and Extended Benefits programs, replacing the blue health care insurance plan card.
- The green health care card entitles holders to all seniors' benefits, hospital and physician services. Persons are eligible for the card if they are a Yukon resident aged 65 years or older, or if they are 60 years of age or older and married to a living Yukon resident who is 65 years of age or older.



Appendix C – Statement of Assessment Explanatory Codes

C.1 Alberta Health Explanatory Codes

05BA INVALID/BLANK REGISTRATION NUMBER

This claim has been refused as the registration number is:

(a) blank

(b) invalid

20E BENEFIT GUIDE

This is an incorrect health service code. Please refer to the applicable benefits schedule.

23A PRIOR APPROVAL

Payment was refused as:

(a) this service requires prior approval from the patient's provincial health plan and/or

(b) prior approval was not received for this date of service.

25 EXCLUDED SERVICE - RECIPROCAL PROGRAMS

Payment was refused as this service is excluded according to the Reciprocal Agreement. Your claim should be billed directly to the patient or, if applicable, their home provincial health plan.

35D CLAIM TYPE

The claim type is invalid or blank.

39BB AGE RESTRICTION

The patient is not eligible for this service due to age.

39BD DATE OF SERVICE/HEALTH SERVICE CODE DATE CONFLICT

The Health Service Code is not effective on this date of service.

63 CLAIM IN PROCESS

Your claim is being held as:

(a) it requires manual assessment or

(b) the supporting information must be reviewed.

DO NOT SUBMIT A NEW CLAIM as notification of payment or refusal will appear on a future Statement of Assessment.

64 SUPPORTING INFORMATION

Payment was refused as text information, an operative or pathology report, or an invoice is required to support assessment of the claim.

67A PREVIOUS PAYMENT

Payment for this service was refused as:

(c) the claim was previously paid, or

(d) the claim was applied at “0” on a previous Statement of Assessment.

67AE PREVIOUS PAYMENT WARD RATE/ICU RATE

Payment was refused as:

(a) the ward rate was previously paid; or

(b) the ICU rate was previously paid.

80G OUTDATED CLAIMS

Payment was refused as the time limit for submission has expired.

95 NEWBORN

Payment was refused as the diagnosis submitted does not agree with the ward rate claimed.

95A IN-PATIENT/OUTPATIENT SERVICES

Payment was refused as an in-patient and an outpatient service provided at the same hospital on the same day to an individual patient is not payable.

95B DAY OF DISCHARGE

Payment has been reduced as the standard ward rate is not payable for the day of discharge.

95C HIGH COST PROCEDURE/ZERO WARD RATE

Payment has been refused as when a high cost procedure and an in-patient standard ward rate are being claimed, two separate claims must be submitted:

(a) one claim showing the admission and discharge date and an in-patient standard ward rate, with the claimed amount of zero, and

(b) the other claim for the high cost procedure.

95D MULTIPLE TRANSPLANTS SAME HOSPITAL STAY

Payment has been refused as multiple same organ transplants within the same hospital stay are not payable.

95E REDUCED BENEFITS

Payment has been reduced as the number of days between the admit date and discharge date do not agree with the claimed amount.

95F OUTPATIENT SERVICES

Payment has been refused as an outpatient hospital service has been previously paid for this patient for this date of service.

95G MAXIMUM NUMBER OF SERVICES

Payment has been refused as the maximum number of services was paid.

95K CLAIM IN PROCESS

Hold for documentation.

95L OUT-OF-PROVINCE REGISTRATION EXPIRY DATE

Payment has been refused as the out-of-province registration expiry date on the claim must be blank if the out-of-province registration number is blank.

95M UNABLE TO PROCESS UPDATED TRANSACTION

The transaction to update a previously submitted claim cannot be processed as:

(a) the original add transaction cannot be located, or

(b) the result of your original claim is unknown, or

(c) the original claim was previously deleted.

Please review your records and resubmit, if applicable.

95N PATIENT RESTRICTIONS FOR PEDIATRIC CARDIOLOGY HIGH COST PROCEDURE

Payment has been refused as High Cost Procedures 550, 551 and 552 are restricted to paediatric cardiology patients from Saskatchewan, Manitoba, British Columbia, Yukon, Northwest Territories and Nunavut.

95P FACILITY AND DATE FORMAT

The claim transaction was refused as it shows an invalid date format and one of the following is incorrect:

(a) the admission date, or

(b) the service date, or

(c) the facility effective date.

95T INVALID ICD10CA DIAGNOSTIC CODE

Payment was refused as the diagnostic code on the claim is invalid. Only the International Statistical Classification of Diseases and Related Health Problems, 10th Canadian Revision, diagnostic codes (ICD10CA) are acceptable for hospital reciprocal in-patient billing.

95U OTHER PROVINCIAL PLAN RESPONSIBILITY

This claim was refused as payment responsibility is between a health zone and another provincial/territory's health plan.

Adjustments Requested by Home Province

96A MOTHER/NEWBORN REGISTRATION NUMBER

This is an adjustment of a previously processed claim. Payment was deducted as the mother's out-of-province registration number may not be used for a baby over the age of three months. Please obtain the baby's correct out-of-province number and resubmit the claim.

96B DECLARATION FORM INCOMPLETE/INCORRECT

This is an adjustment of a previously processed claim. Payment was deducted as the Declaration Form requested by the patient's home province was:

(a) not provided, or

(b) incomplete, or

(c) not signed by the patient or parent/guardian.

96C OUT-OF-PROVINCE PATIENT INFORMATION/CLAIM INFORMATION DISCREPANCY

This is an adjustment of a previously processed claim. Payment was deducted because there is a discrepancy between:

(a) the home province's patient registration information and the patient information submitted; or

(b) the expiry date on the patient's health card and the expiry date on the claim.

96D OUT-OF-PROVINCE PATIENT'S COVERAGE NOT EFFECTIVE

This is an adjustment of a previously processed claim. Payment was deducted as the patient's home province has verified that the patient's health card was not valid on the:

(a) date of service, or
(b) admission date, or
(c) discharge date

96E INCORRECT CLAIM – ALBERTA RESPONSIBILITY

Our records indicate that the patient was an Alberta resident on the date of service; therefore, this claim has been:

(a) refused, or
(b) adjusted from your previous payment.

96F WORKERS' COMPENSATION BOARD RESPONSIBILITY

This is an adjustment of a previously processed claim. Payment was deducted as we have received information advising this service is the responsibility of the Workers' Compensation Board. This claim should be submitted directly to the Workers' Compensation Board.

96G INCORRECT SERVICE/DATE OF SERVICE/RATE CLAIMED

This is an adjustment of a previously processed claim. Payment was deducted at the request of the patient's home province as an incorrect:

(a) service, or
(b) date of service, or
(c) rate was claimed. Please resubmit a new claim using the correct information, if applicable.

96H SECOND OUTPATIENT VISIT

This is an adjustment of a previously processed claim. Payment was deducted as multiple outpatient visits on the same day for the same patient are not payable.
Note: Charges for additional outpatient visits may not be billed directly to the patient or home province.

Adjustments Requested by Alberta Hospital/Health Zone

97A INCORRECT SERVICE/DATE OF SERVICE/RATE CLAIMED

This is an adjustment of a previously processed claim. Payment was deducted at the request of the Alberta hospital/health zone as an incorrect:

(a) service, or
(b) date of service, or
(c) rate was claimed. Please resubmit a new claim using the correct information, if applicable.

C.2 IHIACC Adjustment/Declaration Request Reason Codes

800 Health card number/plan registration number is invalid/blank; does not pass check digit routine, not on master file.
801 Patient not registered; if in-patient, provide a completed Declaration form.
802 Dependant not on master file/database.
803 Patient's coverage not effective for date of service/admission.
804 Patient's coverage expired prior to date of service/admission.
805 Date of admission prior to Plan registration effective date; provide a completed Declaration form.
806 Date of admission after Plan registration termination date; provide a completed Declaration form.
807 Incomplete patient information on Declaration form.
808 Patient's/parent's/guardian's/representative's signature missing on Declaration form.
809 Patient registered in another province/territory.
810 Patient's health card expired; date of service/admission after expiry date.
811 Provide a Declaration form.
812 Declaration form incomplete, adjustment granted.
813 Declaration form not received, requesting adjustment.
814 No response received to previous request.
815 Request closed – claim received and adjusted.
816 Request closed – rule no longer applies.
817 Invalid adjustment reference indicator.
818 Invalid/blank deceased indicator.
819 Invalid/blank out-of-province/territory registration number expiry date.
820 Admission/separation date blank or invalid.
821 Invalid coding scheme type code.
822 Invalid second visit code.
823 Invalid/blank city name/province/territory.
824 Service code/high cost procedure code not effective for date of service.
825 Invalid/blank patient's surname/given name.
826 Invalid/blank patient's address/postal code.
827 Invalid/blank patient's date of birth.
828 Invalid/blank patient's gender code.
829 Invalid/blank diagnostic code(s).
830 Invalid/blank procedure code.
831 Invalid/blank high cost procedure code.
832 Invalid/blank outpatient service code.
833 Invalid/blank admission date/billing date.
834 Invalid/blank discharge/billing end date.
835 Invalid/blank outpatient service date.
836 Invalid/blank high cost procedure date(s).
837 Invalid/blank ward rate.
838 Invalid/blank outpatient rate.
839 Invalid/blank high cost procedure rate(s).
840 High cost procedure code supplied without corresponding procedure code(s).
841 Patient discharged within 48 hours of high cost procedure.
842 Invalid/blank hospital number.
843 Original practitioner identifier/specialty code/number of calls/pay to code/service end date are not applicable for Hospital Reciprocal.
844 Invalid/blank submission type (in-patient/outpatient) segment type.
845 High cost procedure date/override amount must be blank if no high cost procedure code.

846 Invalid code scheme.
847 Invalid accident code/indicator/continuous stay type.
848 Invalid/blank adjustment amount.
849 Invalid adjustment reason indicator.
850 Duplicate outpatient claims, same hospital.
851 Duplicate in-patient to outpatient, same hospital.
852 Duplicate in-patient claims, same hospital.
853 Overlapping service/admission dates.
854 Claim over one year old.
855 Adjustment request over the 18 month time limit.
856 Excluded service.
857 Incorrect amount billed.
858 Prior approval required for service provided.
859 Third outpatient visit claimed; hospital must bill patient's province/territory of residence directly.
860 Other reason (province/territory provide reason/explanation)
861 Patient must be 18 years of age or older for procedure.
862 Maximum number of services reached.
863 Multiple outpatient services same hospital.
864 Duplicate claim.
865 Admission/service/billing date less than birth date.
866 Billing end date must be equal or greater than billing start date.
867 Separation date must be equal or greater than admission date.
868 Invalid claim/high cost procedure override amount.
869 Service event code must be 'I' or 'O' for HREC claim type.
870 Admission/Service date prior to 'NU' (Nunavut) effective date.
872 Existing claim not found for incoming delete claim.
873 Declaration received.
874 Address cannot be specified with outpatient claims.
875 Invalid Stay Type.
876 Discharge date cannot be specified with outpatient claims.
877 Service start date cannot be specified with in-patient claims.
878 Service code effective date invalid.

900 Patient not registered; not on master file.
901 Dependent not on master file/database (not used in AB).
902 Patient's coverage effective date after date of service.
903 Patient's coverage effective after date of admission.
904 Patient's registration expired; no coverage for date of service.
905 Patient's registration expired; no coverage for the date of admission.
906 Declaration of Health Insurance Coverage form sent.
916 Invoice Received
925 Patient's surname/given name provided.
926 Patient's address/postal code provided.
927 Patient's date of birth provided.
928 Patient's valid registration number provided.
929 Diagnostic code provided
930 Procedure code(s) provided.
931 High cost procedure code(s) provided.
932 High cost procedure code(s) provided.
933 Valid out-patient service code(s) provided.
934 Valid admission date provided.
935 Valid discharge date provided.
936 Valid out-patient service date provided.
937 Valid high cost procedure date(s) provided.

938 Valid/correct ward rate provided.
939 Valid/correct high cost procedure rate provided.
940 Procedure code provided for high cost procedure(s).
941 Patient discharged after 48 hours of high cost procedure code claimed.
942 Valid hospital number provided.
950 Duplicate out-patient claims, different hospital.
951 Duplicate in-patient to out-patient different hospital.
952 Duplicate in-patient claims, hospital transfer.
953 Claim over one year old approved for submission.
954 Prior approval provided.
955 Adjustment request beyond the 18 month time limit.
956 Duplicate adjustment request; adjustment processed previously.
957 Other reason for denial (province/territory provide explanation).

Appendix D – CCI Codes for High Cost Procedures

D.1 Outpatient High Cost Special Implant/Device CCI Codes

Cardiac pacemakers and/or defibrillators (any type)/cochlear implants/stents/endovascular coils:

Cardiac pacemakers and/or defibrillators (any type)

Refers to cardiac devices. Does not include temporary pacemakers or artificial heart.

CCI codes:

Percutaneous transluminal (transvenous) approach or approach NOS:

1HZ53GRNM	single chamber rate responsive pacemaker
1HZ53GRNK	dual chamber rate responsive pacemaker
1HZ53GRNL	fixed rate pacemaker
1HZ53GRFS	cardioverter/defibrillator
1HZ53GRFR	cardiac resynchronization therapy pacemaker
1HZ53GRFU	cardiac resynchronization therapy defibrillator

Percutaneous approach (to tunnel subcutaneously):
1HZ53HNFS cardioverter/defibrillator

Open (thoracotomy) approach:

1HZ53LANM	single chamber rate responsive pacemaker
1HZ53LANK	dual chamber rate responsive pacemaker
1HZ53LANL	fixed rate pacemaker
1HZ53LAFS	cardioverter/defibrillator
1HZ53LAFR	cardiac resynchronization therapy pacemaker
1HZ53LAFU	cardiac resynchronization therapy defibrillator

Open Subxiphoid approach:

1HZ53QANM	single chamber rate responsive pacemaker
1HZ53QANK	dual chamber rate responsive pacemaker
1HZ53QANL	fixed rate pacemaker

Combined open (thoracotomy) approach and percutaneous transluminal (transvenous) approach:

1HZ53SYFS	cardioverter/defibrillator
1HZ53SYFR	cardiac resynchronization therapy pacemaker
1HZ53SYFU	cardiac resynchronization therapy defibrillator

Cochlear Implants:

CCI codes:

1DM53LALK	Implantation of internal device, cochlea, of single channel cochlear implant
1DM53LALL	Implantation of internal device, cochlea, of multi-channel cochlear implant

Category does not include reposition of an existing, previously placed implant
(1DM54^^) PCI (Percutaneous Coronary Intervention) with Stents (including drug eluting stents):

CCI codes:

1IJ50GQNR	Dilation, coronary arteries percutaneous transluminal approach [e.g. with angioplasty alone] using (endovascular) stent only
1IJ50GQOA	Dilation, coronary arteries percutaneous transluminal approach [e.g. with angioplasty alone] using balloon or cutting balloon dilator with (endovascular) stent - 1.IJ.50.GQ-OB Dilation, coronary arteries percutaneous transluminal approach [e.g. with angioplasty alone] using laser (and balloon) dilator with (endovascular) stent
1IJ50GQOB	Dilation, coronary arteries percutaneous transluminal approach [e.g. with angioplasty alone] using laser (and balloon) dilator with (endovascular) stent
1IJ50GQOE	Dilation, coronary arteries percutaneous transluminal approach [e.g. with angioplasty alone] using ultrasound (and balloon) dilator with (endovascular) stent
1IJ50GUOA	Dilation, coronary arteries percutaneous transluminal approach with thrombectomy using balloon or cutting balloon dilator with (endovascular) stent
1IJ50GUOB	Dilation, coronary arteries percutaneous transluminal approach with thrombectomy using laser (and balloon) dilator with (endovascular) stent
1IJ50GUOE	Dilation, coronary arteries percutaneous transluminal approach with thrombectomy using ultrasound (and balloon) dilator with (endovascular) stent
1IJ50GTOA	Dilation, coronary arteries percutaneous transluminal approach with atherectomy [e.g. rotational, directional, extraction catheter, laser] using balloon or cutting balloon dilator with (endovascular) stent
1IJ50GTOB	Dilation, coronary arteries percutaneous transluminal approach with atherectomy [e.g. rotational, directional, extraction catheter, laser] using laser (and balloon) dilator with (endovascular) stent
1IJ50GTOE	Dilation, coronary arteries percutaneous transluminal approach with atherectomy [e.g. rotational, directional, extraction catheter, laser] using ultrasound (and balloon) dilator with (endovascular) stent

Stent Grafts:

Stent graft procedure is a procedure that uses percutaneous transluminal approach and (endovascular) stent with synthetic graft. EVAR related CCI codes are excluded from this procedure group.

CCI codes:

1IM80GQNRN	Repair, pulmonary artery, using percutaneous transluminal approach and (endovascular) stent with synthetic tissue [e.g. stent graft].
1JK80GQNRN	Repair, subclavian artery, using percutaneous transluminal approach and (endovascular) stent with synthetic tissue (e.g. stent graft).
1KE80GQNRN	Repair, abdominal arteries NEC, using percutaneous transluminal (arterial) approach and (endovascular) stent graft [e.g. snorkel stent graft].
1KG56GQNRN	Removal of foreign body, arteries of leg NEC using percutaneous transluminal approach and (endovascular) stent with synthetic graft [e.g. stent graft]
1KG80GQNRN	Repair, arteries of leg NEC using percutaneous transluminal approach and (endovascular) stent with synthetic graft [e.g. stent graft].
1KT80GQNRN	Repair, vessels of the pelvis, perineum and gluteal region using percutaneous transluminal (arterial) approach and (endovascular) stent graft.

Endovascular Coiling:

Endovascular coiling or endovascular embolization, is a surgical treatment for cerebral aneurysms. This is intended to prevent rupture in unruptured aneurysms, and rebleeding in ruptured aneurysms. The treatment uses detachable coils made of platinum that are inserted into the aneurysm using the microcatheter.

CCI codes:

1JW51GQGE	Occlusion, intracranial vessels percutaneous transluminal approach using [detachable] coils

D.2 In-patient High Cost Special Implant/Device CCI Codes

Service Code	Description	CCI Codes
310	Cochlear implants	1DM53LALK Implantation of internal device, cochlea of single channel cochlear implant 1DM53LALL Implantation of internal device, cochlea of multi- channel cochlear implant Category does not include reposition of an existing, previously placed implant (1.DM054M)
311	Cardiac pacemakers and/or defibrillators (any type) ICD etc	Percutaneous transluminal (transvenous) approach or approach NOS: 1HZ53GRNM single chamber rate responsive pacemaker

	Does not include temporary pacemakers or artificial heart.	1HZ53GRNK dual chamber rate responsive pacemaker 1HZ53GRNL fixed rate pacemaker 1HZ53GRFS cardioverter/defibrillator 1HZ53GRFR cardiac resynchronization therapy pacemaker 1HZ53GRFU cardiac resynchronization therapy defibrillator Percutaneous approach (to tunnel subcutaneously): 1HZ53HNFS Implementation of internal device, heart NEC cardioverter/defibrillator Open (thoracotomy) approach: 1HZ53LANM single chamber rate responsive pacemaker 1HZ53LANK dual chamber rate responsive pacemaker 1HZ53LANL fixed rate pacemaker 1HZ53LAFS cardioverter/defibrillator 1HZ53LAFR cardiac resynchronization therapy pacemaker 1HZ53LAFU cardiac resynchronization therapy defibrillator Open Subxiphoid approach: 1HZ53QANM single chamber rate responsive pacemaker 1HZ53QANK dual chamber rate responsive pacemaker 1HZ53QANL fixed rate pacemaker Combined open (thoracotomy) approach and percutaneous transluminal (transvenous) approach: 1HZ53SYFS cardioverter/defibrillator 1HZ53SYFR cardiac resynchronization therapy pacemaker 1HZ53SYFU cardiac resynchronization therapy defibrillator
312	Aortic valve (aka TAVI). Implantation of xenograft aortic valve replacement without excision of native valve, via transcatheter approach.	1HV90GQXXL Excision total with reconstruction, aortic valve, replacement of valve alone with xenograft tissue valve [e.g. bovine or porcine tissue] using percutaneous transluminal (transcatheter) arterial approach. 1HV90GRXXL Excision total with reconstruction, aortic valve replacement of valve alone with xenograft tissue valve [e.g. bovine or porcine tissue] using percutaneous transluminal (transcatheter) (transseptal) venous approach. 1HV90STXXL Excision total with reconstruction, aortic valve, replacement of valve alone with xenograft tissue valve [e.g. bovine or porcine tissue] using closed heart technique (transapical) (transcatheter). Notes: The CIHI Classifications and Terminologies staff has advised Health Canada that the IHIACC approved service code 312 Aortic valve CCI codes are the most suitable to describe this procedure and confirm a Grade 1 match (best fit). The CCI classification is designed to categorise procedures for analysis and it is not always possible to identify a procedure uniquely.
313	Ventricular assist device. VAD includes the mechanical pump (all forms: external, implanted or paracorporeal), implant kit, external controller with backup, main AC power source with patient cables, batteries, charger, DC adapter for car, monitor to communicate information regarding VAD function and to enable program setting changes to VAD controller, and necessary accessories including cannulae and circuits specific to the device, blood flow Doppler,	1HP53GPQP Implantation of internal device, ventricle, of ventricular assist pump using percutaneous transluminal approach [e.g. Impella] 1HP53LAQP Implantation of internal device, ventricle, of ventricular assist pump using open approach [e.g. HeartMate, Novacor] The codes assigned include the following, in CCI: • Insertion, biventricular assist device [BiVAD] • Insertion, left ventricular assist device [LVAD] • Insertion, right ventricular assist device [RVAD]

	water proof VAD shower bag, vests, battery holster and belts.	• Insertion, ventricular assist device [VAD]
		  ○ that for long-term therapy [e.g. destination therapy]
		  ○ that for short-term therapy [e.g. bridge-to-transplant or bridge-to-recovery therapy]
		
		The assigned codes do not include adjustment, repositioning or removal of VADs

314	Abdominal aorta knitted grafts, stents	1KA57LAXXA Extraction, abdominal aorta open approach using autograft using device NEC. Additional CCI codes: 1KA80GQNRN - using percutaneous transluminal (arterial) approach and (endovascular) stent graft, 1KA80LAXXN using open approach with synthetic material [e.g. Teflon felt, Dacron, Nylon, Orlon], 1KA76MZXXN. Knitted graft, Spiral-z iliac stent, reliant stent graft.
315	Cranium screws, wires, mesh, plates used in release/repair	1EA72LANW Release, cranium open approach using plate, screw device (with/without wire or mesh) no tissue used (in the release) 1EA72LANWA Release, cranium open approach using plate, screw device (with/without wire or mesh) with autograft 1EA72LANWQ Release, cranium open approach using plate, screw device (with/without wire or mesh) with combined sources of tissue [e.g. graft and flap] 1EA72LANWG Release, cranium open approach using plate, screw device (with/without wire or mesh) with pedicled flap [pericranial flap] 1EA72LAKD Release, cranium open approach using wire or mesh only no tissue used (in the release) 1EA72LAKDA Release, cranium open approach using wire or mesh only with autograft 1EA72LAKDQ Release, cranium open approach using wire or mesh only with combined sources of tissue [e.g. graft and flap] 1EA72LAKDG Release, cranium open approach using wire or mesh only with pedicled flap [pericranial flap]
316	Implantation, thalamus and basal ganglia, of electrodes using burr hole approach	1AE53SEJA Implantation of internal device, thalamus and basal ganglia of electrodes [e.g. recording, stimulating] using burr hole approach.
317	Artificial knee used in bilateral and unilateral revision/replacement	Single component: 1VG53LAPMN Implantation of internal device, knee joint, knee joint with synthetic material (e.g. bone paste, cement, Dynagraft, Osteoset) single component prosthetic device 1VG53LAPM Implantation of internal device, knee joint, knee joint uncemented single component prosthetic device 1VG53LAPMA Implantation of internal device knee joint with bone autograft single component prosthetic device 1VG53LAPMK Implantation of internal device, knee joint, knee joint with bone homograft single component prosthetic device 1VG53LAPMQ Implantation of internal device, knee joint, knee joint with combined sources of tissue (e.g. bone graft, cement, paste) single component prosthetic device Dual component:

		1VG53LAPNN Implantation of internal device, knee joint, knee joint with synthetic material (e.g. bone paste, cement, Dynagraft, Osteoset) dual component prosthetic device 1VG53LAPN Implantation of internal device, knee joint uncemented using dual component prosthetic device 1VG53LAPNA Implantation of internal device, knee joint, knee joint with bone autograft dual component prosthetic device 1VG53LAPNK Implantation of internal device, knee joint, knee joint with bone homograft dual component prosthetic device 1VG53LAPNQ Implantation of internal device, knee joint, knee joint with combined sources of tissue (e.g. bone graft, cement, paste) dual component prosthetic device <u>Tri component</u>: 1VG53LAPPN Implantation of internal device, knee joint, knee joint with synthetic material (e.g. bone paste, cement, Dynagraft, Osteoset) tri component prosthetic device 1VG53LAPP Implantation of internal device, knee joint, knee joint uncemented tri component prosthetic device 1VG53LAPPK Implantation of internal device, knee joint, knee joint with bone homograft tri component prosthetic device 1VG53LAPPA Implantation of internal device, knee joint, knee joint with bone autograft tri component prosthetic device 1VG53LAPPQ Implantation of internal device, knee joint, knee joint with combined sources of tissue (e.g. bone graft, cement, paste) tri component prosthetic device Partial component : 1VG53LAPR Implantation of internal device, knee joint uncemented partial component [e.g. tibial liner (insert) alone] The host jurisdiction does not need to record the status attribute.
318	Spinal fixation/fusion rods, grafts, screws	1SA74^^ Fixation, <u>atlas and axis</u> (all codes) 1SA75^^ Fusion, atlas and axis (all codes) 1SC74^^ Fixation, spinal vertebrae and 1SC75^^ Fusion, spinal vertebrae EXCLUDING codes with device qualifier XX meaning ‘no device used.
319	Artificial hip used in unilateral replacement (excludes bilateral and revised)	1VA53^^ with the exception of 1VA53LASLN which is the implantation of a cement spacer only If an invoice is requested, a note should be added to the invoice that indicates the status and location attribute (status attribute of ‘P’ (primary) and a location attribute of either ‘L’ for left or ‘R’ for right).
320	Artificial shoulder used in shoulder revision/replacement	1TA53LAPM, 1TA53LAPMA, 1TA53LAPMK, 1TA53LAPMN, 1TA53LAPMQ, 1TA53LAPN, 1TA53LAPNA, 1TA53LAPNK, 1TA53LAPNN, 1TA53LAPNQ, 1TA53LAPQ, 1TA53LAPQA, 1TA53LAPQK, 1TA53LAPQN, 1TA53LAPQQ, 1TA53LASLN If an invoice is requested, a note should be added to the invoice that indicates the status attribute of ‘R’ (revision).

321	Stent grafts Stent graft procedure is a procedure that uses percutaneous transluminal approach and (endovascular) stent with synthetic graft. EVAR related CCI codes are excluded from this procedure group.	1IM80GQNRN Repair, pulmonary artery, using percutaneous transluminal approach and (endovascular) stent with synthetic tissue [e.g. stent graft]. 1JK80GQNRN Repair, subclavian artery, using percutaneous transluminal approach and (endovascular) stent with synthetic tissue (e.g. stent graft). 1KE80GQNRN Repair, abdominal arteries NEC, using percutaneous transluminal (arterial) approach and (endovascular) stent graft [e.g. snorkel stent graft]. 1KG56GQNRN Removal of foreign body, arteries of leg NEC using percutaneous transluminal approach and (endovascular) stent with synthetic graft [e.g. stent graft]. 1KG80GQNRN Repair, arteries of leg NEC using percutaneous transluminal approach and (endovascular) stent with synthetic graft [e.g. stent graft]. 1KT80GQNRN Repair, vessels of the pelvis, perineum and gluteal region using percutaneous transluminal (arterial) approach and (endovascular) stent graft.
322	Expandable stent graft used in endovascular aneurysm repairs (EVAR) Endovascular aneurysm repair or endovascular aortic repair (EVAR) is a type of endovascular surgery used to treat an abdominal aortic aneurysm. The procedure involves the placement of an expandable stent graft within the aorta to treat the aortic disease without surgically opening or removing part of the aorta.	1ID80GQNRR, 1ID80GQNRN, 1KA80GQNRR , 1KA50GQOA
323	Transcatheter pulmonary valve Pulmonary valve treatment is a procedure wherein an artificial heart valve is delivered via catheter through the cardiovascular system. The catheter is inserted into the patient's femoral vein through a small access site. The catheter which holds the valve is placed in the vein and guided into the patient's heart. Once the valve is in the right position, the balloons are inflated and the valve expands into place and blood will flow between the patient's right ventricle and lungs.	1HT90GPXXL Excision total with reconstruction, pulmonary valve using percutaneous transluminal approach with xenograft [e.g. Melody stent valve].

Appendix E – PET-CT Scan Approved Clinical Indicators

E.1 PET-CT clinical indicators for reciprocal billing only

CANCER TYPE	CLINICAL INDICATION	ICD-10-CA Codes for Cancer Type	CCI Codes
ESOPHAGEAL CANCER	Staging prior to surgery; for baseline staging assessment of those patients diagnosed with esophageal cancer being considered for curative therapy and/or repeat PET-CT scan on completion of pre-operative/ neoadjuvant therapy, prior to surgery	**C15.–** *Malignant neoplasm of oesophagus*	3.**.70.CJ
COLORECTAL CANCER	Staging for potentially resectable recurrences (including rising CEA); where recurrent disease is suspected on the basis of an elevated and/or rising carcinoembryonic antigen (CEA) level(s) during follow-up after surgical resection but standard imaging tests are negative or equivocal PET-CT for apparent limited metastatic disease, such as organ-restricted liver or lung metastases, or limited nodal metastases (at presentation or follow-up) who are being considered for radical intent therapy, such as ablation, radiotherapy, or surgery. PET-CT should be considered prior to chemotherapy where the identification of occult metastases prior to resection or chemotherapy may render resection inappropriate or may alter a patient's management; or 6 weeks post chemotherapy	**C18.–** *Malignant neoplasm of colon* **C19** *Malignant neoplasm of rectosigmoid junction* **C20** *Malignant neoplasm of rectum* **C78.–** *Secondary malignant neoplasm of respiratory and digestive organs* **R76.8** *Other specified abnormal immunological findings in serum*	3.**.70.CJ
GYNECOLOGICAL CANCER	Staging locally advanced cervical cancer; PET- CT for patients with locally advanced cancer of the cervix (+/- endometrial cancer) with positive or equivocal pelvic lymph nodes as assessed by PET-CT Re-staging prior to consideration of pelvic exenteration; PET-CT for patients with recurrent gynecologic malignancies under consideration for radical salvage surgery	**C51.–** *Malignant neoplasm of vulva* **C52** *Malignant neoplasm of vagina* **C53.–** *Malignant neoplasm of cervix uteri* **C54.–** *Malignant neoplasm of corpus uteri* **C55** *Malignant neoplasm of uterus, part unspecified* **C56.–** *Malignant neoplasm of ovary* **C57.–** *Malignant neoplasm of other and unspecified female genital organs* **C58** *Malignant neoplasm of placenta* **C77.–** *Secondary and unspecified malignant neoplasm of lymph nodes*	3.**.70.CJ

CANCER TYPE	CLINICAL INDICATION	ICD-10-CA Codes for Cancer Type	CCI Codes
HEAD AND NECK	Diagnosis of the primary site; for the evaluation of metastatic squamous cell carcinoma in neck nodes when the primary disease site is unknown after standard radiologic and clinical investigation For the staging on nasopharyngeal cancer PET-CT to assess patients with N1, N2, or N3 metastatic squamous cell carcinoma of the head and neck, after chemoradiation, who have residual neck nodes of 1.5cm or greater on re- staging PET-CT performed 10-12 weeks post therapy Staging of patients with of locally advanced (N1, N2, or N3) malignancies of the head and neck	**C00.–** *Malignant neoplasm of lip* **C01** *Malignant neoplasm of base of tongue* **C02.–** *Malignant neoplasm of other and unspecified parts of tongue* **C03.–** *Malignant neoplasm of gum* **C04.–** *Malignant neoplasm of floor of mouth* **C05.–** *Malignant neoplasm of palate* **C06.–** *Malignant neoplasm of other and unspecified parts of mouth* **C07** *Malignant neoplasm of parotid gland* **C08.–** *Malignant neoplasm of other and unspecified major salivary glands* **C09.–** *Malignant neoplasm of tonsil* **C10.–** *Malignant neoplasm of oropharynx* **C11.–** *Malignant neoplasm of nasopharynx* **C12** *Malignant neoplasm of pyriform sinus* **C13.–** *Malignant neoplasm of hypopharynx* **C14.–** *Malignant neoplasm of other and ill-defined sites in the lip, oral cavity and pharynx* **C30.0–** *Malignant neoplasm of nasal cavity* **C31.–** *Malignant neoplasm of accessory sinuses* **C32.–** *Malignant neoplasm of larynx* **C41.–** *Malignant neoplasm of bone and articular cartilage of other and unspecified sites* **C49.0** *Malignant neoplasm of connective and soft tissue of head, face and neck* **C69.5** *Malignant neoplasm lacrimal gland & duct* **C76.0** *Malignant neoplasm of head, face and neck* **C77.0** *Secondary malignant neoplasm lymph nodes of head, face and neck*	3.**.70.CJ
MELANOMA	Staging in node positive disease for whom radical surgery is planned; for the staging of melanoma patients with localized “high risk” tumours with potentially resectable disease; or for the evaluation of patients with melanoma and isolated metastasis at the time of recurrence when metastectomy is being contemplated	**C43.–** *Malignant melanoma of skin* **C77.–** *Secondary and unspecified malignant neoplasm of lymph nodes* **C78.–** *Secondary malignant neoplasm of respiratory and digestive organs* **C79.–** *Secondary malignant neoplasm of other and unspecified sites*	3.**.70.CJ
LUNG	Solitary Pulmonary Nodule (SPN) (solid or semi- solid, excluding GGN), undiagnosed in patients at high risk from TTNB; SPN: a lung nodule for which a diagnosis could not be established by a needle biopsy due to unsuccessful attempted needle biopsy; the SPN is inaccessible to needle	**C34.–** *Malignant neoplasm of bronchus and lung* **C77.–** *Secondary and unspecified malignant neoplasm of lymph nodes* **C78.–** *Secondary malignant neoplasm of respiratory and digestive organs*	3.**.70.CJ

CANCER TYPE	CLINICAL INDICATION	ICD-10-CA Codes for Cancer Type	CCI Codes
	biopsy; or the existence of a contra-indication to the use of needle biopsy	**C79.–** *Secondary malignant neoplasm of other and unspecified sites* **J98.4** *Other disorders of lung*	
	For initial staging of patients being considered for potentially curative therapy based on negative standard imaging tests; OR for staging of patients with locoregional recurrence, after primary treatment, being considered for definitive salvage therapy		
	Initial staging, restaging, recurrent disease or multiple primaries being considered for potentially curative therapy		
	For staging of patients with locoregional recurrence, after primary treatment, being considered for definitive salvage therapy		
	Staging if limited stage disease is suspected and may be indicated for limited use in radiation treatment planning in patients with small cell lung cancer; Small cell lung cancer: limited disease small cell lung cancer where combined modality therapy with chemotherapy and radiotherapy is being considered		
LYMPHOMA	Baseline staging of patients with aggressive lymphomas being considered for curative intent treatment; for the baseline staging of patients with indolent lymphomas being considered for aggressive/curative therapy	**C81.–** *Hodgkin lymphoma* **C82.–** *Follicular lymphoma* **C83.–** *Non-follicular lymphoma* **C84.–** *Mature T/NK-cell lymphomas* **C85.–** *Other and unspecified types of non-Hodgkin lymphoma* **C86.–** *Other specified types of T/NK-cell lymphoma* **C88.4–** *Extranodal marginal zone B-cell lymphoma of mucosa-associated lymphoid tissue [MALT-lymphoma]*	3.**.70.CJ
	Evaluation of residual mass(es) following chemotherapy in a patient with Hodgkin's or non- Hodgkin's lymphoma when further potentially curative therapy (such as radiation or stem cell transplantation) is being considered;		
	Assessment of response in Hodgkin's lymphoma after two (2) or three (3) cycles of chemotherapy, when chemotherapy is being considered as the definitive single modality therapy		
TESTICULAR CANCER	Evaluation of residual mass; Germ cell tumours: where persistent disease is suspected on the basis of the presence of a residual mass after primary treatment for seminoma when curartive surgical resection is being considered	**C62.–** *Malignant neoplasm of testis*	3.**.70.CJ

CANCER TYPE	CLINICAL INDICATION	ICD-10-CA Codes for Cancer Type	CCI Codes
	Germ cell tumours: where recurrent disease is suspected on the basis of elevated tumour marker(s) - (beta human chorionic gonadotrophin (HCG) and/or alpha fetoprotein) and standard imaging tests are negative		
THYROID CARCINOMA	Detection of suspected recurrence based on rising TG with negative Iodine-131 scan; where recurrent or persistent disease is suspected on the basis of an elevated and/or rising thyroglobulin level(s) but standard imaging studies, including I-131 scan and/or neck ultrasound, are negative or equivocal	**C73** *Malignant neoplasm of thyroid gland*	3.**.70.CJ