Alberta Government

Bulletin

Alberta Health Care Insurance Plan

Number: ARP 3	Date: December 6, 2019	
Subject: New ARP Service Codes for Clinical ARP Participating Physicians	**Reference:** Clinical ARP Program Parameters; Clinical ARP Conditions of Payment	

To: All Clinical Alternative Relationship Plan (ARP) Participating Physicians and billing staff

Alberta Health is introducing new Alternative Relationship Plans (ARP) Service Codes for **service dates starting January 1, 2020**. Clinical ARP Participating Physicians may use these new codes for Service Event Reporting to the Ministry of Health. The change in code use will not be applied to physicians in the Academic Medicine and Health Services Program (AMHSP) at this time.

a) All Clinical ARP Participating Physicians must continue to use the Schedule of Medical Benefits (SOMB) health Service Codes to submit their Service Event Reporting to the Ministry, whenever applicable. A complete listing of SOMB health Service Codes is available on the Alberta Health website at: www.alberta.ca/fees-health-professionals.aspx.
    - The Alberta Medical Association Navigator may also help you with your search for pertinent health Service Codes: www.albertadoctors.org/fee-navigator.

b) In addition to the SOMB health Service Codes, effective January 1, 2020, Clinical ARP Participating Physicians may also use the following newly created ARP Service Codes when the SOMB codes are not applicable for capturing the service provided. As each Clinical ARP provides different services, all Participating Physicians may not need to use all of the new ARP Service Codes.
    - Clinical ARP Participating Physicians may use the Allied Procedure List (APL) (non-SOMB) codes for Program Services provided up to and including December 31, 2019.

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- For services provided from January 1-31, 2020, Alberta Health encourages Participating Physicians to use the new ARP Service Codes; however, to facilitate the transition to the new codes, the old APL (non-SOMB) codes may still be used for reporting services provided during this period.
- For services provided after January 31, 2020, Participating Physicians will no longer be able to use the old APL (non-SOMB) codes and can only use the new ARP Service Codes.
- All existing billing processes will remain the same.

New Alternative Relationship Plan Service Codes

ARPs involve the delivery of programs established pursuant to Section 3.1 of the *Medical Benefits Regulation*. They consist of Clinical ARPs as described in the Clinical ARP Program Parameters and Clinical ARP Conditions of Payment Ministerial Orders, and AMHSP as described in the AMHSP Master Agreements. ARPs allow physicians to be compensated for the delivery of defined program services, including insured medical services, in a manner other than under a Fee-For-Service model. ARPs require physicians to submit claims for benefits using health Service Codes described in the SOMB. If existing SOMB health Service Codes do not capture the service being delivered or the time required to deliver a service under an ARP, then ARP Service Codes should be used to capture the service and/or time the SOMB health Service Codes are not able to capture.

Alternative Relationship Plan Service Codes	
S001	Time spent in preparation/research related to the care of a complex Patient (E.g. a Patient with co-morbidities which complicate or increase the care required by the claiming physician), per five minutes. • May only be claimed on any day prior to the date that a Patient is seen. • May not be claimed on the day that a Patient is seen as applicable health Service Codes in the SOMB (and appropriate modifiers) including time spent on the day that a Patient is seen. • Must be documented in the Patient record. • Claim using the Patient-specific unique lifetime identifier (ULI).

S002	Time spent waiting for a Patient who did not attend a scheduled appointment, per five minutes. • If being claimed under a Clinical ARP, the claiming physician must be present at the Centre, and may only be claimed up to the maximum time specified in the Clinical ARP Conditions of Payment, Schedule A, Article 3. • Claim using the Patient-specific ULI.
S003	Time spent waiting for drop-in Patients, per five minutes. • May only be claimed by ARPs authorized by Alberta Health to use this code. • If being claimed under a Clinical ARP, the claiming physician must be present at the Centre, and may only be claimed up to the maximum time specified in the Clinical ARP Conditions of Payment, Schedule A, Article 3. • Details regarding the time claimed must be documented and made available upon request. • Claim using the non-Patient-specific ULI.
S004	Any communication, including but not limited to, informal, non-scheduled discussions, meetings, interviews, and conferences, with a Physician, Allied Health Professional, schools, agencies, boards, committees, or relatives, regarding advice or care of a Patient, per five minutes. • May not be claimed if current SOMB codes apply. • May be claimed regardless of who initiates the communication. • If the communication is by electronic means, may only be claimed when in compliance with the College of Physicians and Surgeons (CPSA) guidelines on secure electronic communication and when the physician/clinic has submitted a Privacy Impact Assessment for this service acceptable to the Office of the Information and Privacy Commissioner of Alberta. • The communication must be documented in the Patient's record. • Claim using the Patient-specific ULI.
S005	Any communication, including but not limited to, informal, non-scheduled discussions, meetings, interviews, and conferences, with a Physician, Allied Health Professional, schools, agencies, boards, committees, or relatives, regarding advice or care of a Patient, per five minutes. • May be claimed regardless of who initiates the communication. • If the communication is by electronic means, may only be claimed when in compliance with the CPSA guidelines on secure electronic communication and when the physician/clinic has submitted a Privacy Impact Assessment for this service acceptable to the Office of the Information and Privacy Commissioner of Alberta. • The communication must be documented and made available upon request. • Claim using the non-Patient-specific ULI.

S006	Second physician at a Patient visit, per five minutes. • May only be claimed by ARPs authorized by Alberta Health to use this code. • May only be claimed by the second physician involved in shared care service. The physician directly involved in the Patient's care must claim the appropriate health service code in the SOMB. • Patient must be present with at least one of the physicians. • Claim using the Patient-specific ULI.
S007	Time spent delivering program services to a Patient who is a resident of Alberta that would be eligible for the Alberta Health Care Insurance Plan (AHCIP) but is not enrolled in the AHCIP, per five minutes. • May only be claimed by ARPs authorized by Alberta Health to use this code. • Details regarding the services delivered must be documented and made available upon request. • Claim using the non-Patient-specific ULI.
S008	Group health education session, per five minutes. • May only be claimed for a session delivered to members of the public or an entirely non-program Patient group. • May not be claimed for a session delivered to other health care providers. • May only be claimed for a topic related to services delivered by the ARP. • May not be claimed for preparation time. • Details of the session must be documented and made available upon request. • Claim using the non-Patient-specific ULI.
S009	Report writing and other clinical documentation related to the care and treatment of a Patient, per five minutes. • May be claimed on any day after the date that a Patient is seen. • May only be claimed on the same day that a Patient is seen if: – a complex modifier has been claimed, and the time spent delivering program services exceeds the time specified by the complex modifier; or – the time spent delivering program services to a Patient exceeds the time captured by the maximum number of calls available under the applicable health service code, and/or any applicable modifiers. • Claim using the Patient-specific ULI. NOTE: This usage is different from health Service Codes claimed as Fee-For-Service and is solely for documenting time spent on the Patient-related activities described.

S010	Review of Patient lab results, consultant reports, or other care reports, per five minutes. • May be claimed on any day after the date that a Patient is seen. • May only be claimed on the same day that a Patient is seen if: – a complex modifier has been claimed, and the time spent delivering program services exceeds the time specified by the complex modifier; or – the time spent delivering program services to a Patient exceeds the time captured by the maximum number of calls available under the applicable health service code, and/or any applicable modifiers. • Claim using the Patient-specific ULI. NOTE: This usage is different from health Service Codes claimed as Fee-For-Service and is solely for documenting time spent on the Patient-related activities described.
S011	Review of Patient lab results, consultant reports, or other care reports for multiple Patients, per five minutes. • Details regarding the time claimed must be documented and made available upon request. • Claim using the non-Patient-specific ULI.
S012	Time spent for work related to ARP business, including but not limited to reporting, completing Letters of Participation, Letters of Termination, Clinical ARP Applications, meeting with Alberta Health, Alberta Health Services, or the ARP Physician Support Services, and development specifically related to the ARP, per five minutes. • If being claimed under a Clinical ARP: – May only be claimed by an Authorized Representative(s) for work related to ARP business and not for program meetings. – May not be claimed if the Authorized Representative(s) receives compensation from another source for work related to Clinical ARP business. • Details regarding the time claimed must be documented and made available upon request. • Claim using the non-Patient-specific ULI.