


AMA Billing Webinar  
Hosted by  
Calgary West-Central  
PCN

September 14, 2021

Host:  
Tracey Ross-Kretschmer  
Calgary West-Central PCN

Presenter:  
Norma Shipley  
AMA Fees Consultant



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• Introductions



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### Land Acknowledgement

*The Alberta Medical Association acknowledges that we are located on Treaty 6, 7, and 8 territories; traditional lands of diverse Indigenous peoples including the Cree, Métis, Nakoda Sioux, Iroquois, Dene, Inuit, Blackfoot Confederacy, the Tsuut'ina First Nation, the Stoney Nakoda and many others whose histories, languages and cultures continue to influence our vibrant community. We respect the histories, languages and cultures of First Nations, Metis, Inuit, and all First Peoples of Canada, whose presence continues to enrich our vibrant community.*



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### Recording

- There has been a request to record this session. Does the group agree:
  - That the recording will not be posted on a publicly available site
  - Access will be managed to those who are eligible to attend this session
  - Attendees and those who may access the recording at a later date further agree that they will not share this recording with those not eligible to attend, including those representing other organizations.



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### Zoom How-To



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



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### Zoom Basics

**\*Locate on your Zoom menu bar:**

-  Microphone is on. Click this icon to mute your microphone.
-  Microphone is muted. Click this icon to unmute your microphone to speak. **If you are not speaking, please keep your microphone muted to reduce audio interference.**
-  Video is on. Click this icon to turn off your camera.
-  Video is off. Click this icon to turn on your camera.

\*Location varies for Microsoft, Apple, iOS, and Android users



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
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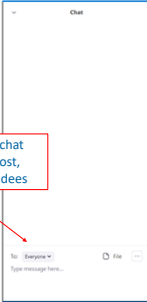
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### Asking Questions

Click the Chat icon to open the in-meeting chat



You can then send chat messages to the host, panelists, and attendees



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
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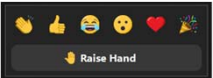
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### Asking Questions

Click the Reactions icon to react using an emoji to communicate without interrupting the meeting. Reactions will disappear after 5 seconds.



Click the Raise Hand emoji if you would like to ask a question out loud. Your Zoom window will move up to the front of the gallery if your hand is raised.



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**Evaluation**

- Your feedback is important – help us understand what information you need
- An evaluation request will be sent to you after the seminar
- Please let us know what you think



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**Session Overview**

- How do I know I'm optimizing my billings under the Rules?
- What about
  - rejections?
  - under used codes?
- New Codes/other developments
- Staying up-to-date
  - When/where are changes published?
  - Include recent changes
- Monitoring
  - Within your practice
  - Alberta Health review



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**Optimizing your Billings**  
Stay on top of the Basics



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### Know Where to Get Help



- Alberta Health Resources
  - [Physician Resource Guide](#)
  - [Schedule of Medical Benefits Procedure List](#)
- Alberta Health
  - 310-0000 780 422-1600
  - Email: [Health.HCIPAPProviderClaims@gov.ab.ca](mailto:Health.HCIPAPProviderClaims@gov.ab.ca)
- AMA – Physician Advocacy
  - 1-800-272-9680 780 482-2626
  - E-mail:
    - [billingadvice@albertadoctors.org](mailto:billingadvice@albertadoctors.org)
    - [norma.shipley@albertadoctors.org](mailto:norma.shipley@albertadoctors.org)
    - [darcy.shade@albertadoctors.org](mailto:darcy.shade@albertadoctors.org)
    - [marisa.bonuccelli@albertadoctors.org](mailto:marisa.bonuccelli@albertadoctors.org)



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### Stay up-to-date

- Read the AMA's Billing Corner and AH Bulletins
  - The codes and rules can and do change
  - Be sure you understand the full code wording, modifier description, rules
- Use the AMA Fee Navigator™
  - [www.albertadoctors.org/feenav](http://www.albertadoctors.org/feenav)
- Download and review the Schedule components:
  - <http://www.health.alberta.ca/professionals/SOMB.html>
- Remember –
  - Paid doesn't mean the claim was correct/appropriate – be sure you understand the requirements
  - Physicians decide what fee code, and how many, to bill!
  - Physicians are responsible for what's claimed in their name

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### Verify Your Patient has AHCIP Coverage

- Check Alberta registration numbers in advance
  - Office
    - Check numbers in advance of service (NetCare or AH IVR)
    - Bill patient if no coverage
    - Make a pay to patient claim when coverage in place
- Out of Province Patients
  - Is the card in the current format?
    - <https://www.alberta.ca/assets/documents/ahcip-valid-insured-health-services-plan-cards-reciprocal-billing.pdf>
  - Copy all OOP cards

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### Know the Submission Deadlines

- Since March 31, 2020, claims must be submitted within:
  - 90 days of date of service, or
  - 90 days of date of last communication from AH
  - If claim is rejected outside 90 days, you can resubmit under a new claim number, with text (original claim number, submission date)
- The Minister may give special permission to submit after that, but it's rare:
  - Disasters (fire, flood, employee theft)
  - Infrequent, little/no flexibility

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### Understand the Daily Visit Cap

0 – 50 Visits	Paid at	100%
51 – 65 Visits	Paid at	50%
>65 Visits	Paid at	0

Affects all communities not receiving the RRNP variable payment rate  
RRNP flat rate communities subject to the cap

- Applies to all V category services
- Includes phone calls to patients, team and family conferences, communication by phone/telehealth with other physicians, health professionals, community agencies (PUVA excluded), but not procedures (e.g., 03.03A with CMGP01 + 13.99BA = 1)
- Also includes home, non-regulated facility visits (e.g. assisted living, designated assisted living), and those billed in location "OTHR" (OTHR indicates service outside a designated facility or office); does not apply to hospital and long term care visits
- Does not apply to rural communities that receive variable RRNP, hospitals, and emergency room services



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### Time-based Services (GR 2.3.6)

- Physicians must document time spent providing time-based services
- How?
  - Keep track of the start/end of your day each day – retain in chronological order
  - Use a log book or calendar in your electronic device
  - Exclude any time for breaks
  - Include any time you spent after office/clinic hours on work related to patients seen that day
  - Retain for 6 years



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**Delegated Services (GR 2.7.5)**

- The Schedule pays for direct physician services to patients
- There are a few exceptions (AHC - MED 97)
  - Technical services (in office)
  - Delegated services (13.42A – allergy desensitization; 13.59A – flu, pneumovac) (nurse working in physician office)
  - Physician in training, other health professional – physician must be in the room, directly supervising for duration of procedure
  - Virtual Care
  - Family and allowed team conferences



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**Pay Attention to Rejected Claims**

- Review claims responses and statement of assessments
- Are any claims rejected or not paid in full?
- Do you understand why?
- Do the explanatory codes make sense?
- If not, investigate

In general, most claims don't require text. Text isn't the solution to resolving a claim issue.

Billing Tip: Don't submit text unless:

- The individual code specifies it's required (e.g., 13.99J), OR
- AH has specifically instructed you to submit text with a revised claim (and only for that claim)



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**Optimizing your Billings**

Reconciliations and Rejections  
Look at the Explanatory Codes

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**Reconciliations and Rejections**

- Claim rejected or paid at \$0?
- Review the explanatory code – why?
- Check your billing software and/or AMA's Fee Navigator®
- Resolve the problem, then resubmit

• CAUTION: Resubmitting with text to force a manual review is not the answer



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**63 – Claim in progress**

- Claim is being held – why?
  - Requires manual assessment
  - Supporting information needs to be reviewed
  - Do not resubmit



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**63A – Payment reduced or refused in accordance with SOMB**

- Review Governing Rules
- Understand the reason
  - 2 visits on the same date?
  - Incorrect encounter number
  - Claimed a procedure not payable with a visit
  - Claimed more calls than are available



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**63A – Payment reduced or refused in accordance with SOMB**

- Review Governing Rules
- Understand the reason
  - 2 visits on the same date?
  - Incorrect encounter number
  - Claimed a procedure not payable with a visit
  - Claimed more calls than are available



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**Preventing Registration Rejections**

- Validate Registration number - IVR 1-888-422-6257 or Netcare
  - All new patients, those not seen for long time, turned 21
  - Patients who have recently moved, or are transient
- Opted out patients
  - Albertans who do not wish to participate in AHCIIP

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**Preventing Registration Rejections**

- Reciprocal billing:
  - Check patient name against photo ID
  - Copy all OOP cards
  - BC IVR # 1-800-742-6165 – check eligibility
  - Bill patients directly if they:
    - can't produce evidence of AB or other provincial health insurance
    - are visiting from Quebec
    - are here temporarily from outside Canada
  - Bill Medavie Blue Cross for:
    - refugees (Interim Federal Health Program)
    - RCMP, CAF members




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**Registration Problems (05)**

Check patient registration via NetCare or AH's IVR phone system  
If patient is not eligible, bill directly

- 05 - Patient Personal Health Number – not effective
- 05A - Personal Health Number is invalid or blank.
- 05AA - The patient has opted out of the Alberta Health Care Insurance Plan
- 05BA - This claim has been refused as the registration number is:
  - (a) blank
  - (b) invalid
- 05BB - This claim has been refused as the Unique Lifetime Identifier is
  - (a) blank
  - (b) invalid
  - (c) not a valid ULI for the Service Recipient




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**Patients with Invalid PHNs**

- Invalid registration number
  - In your office
    - Check patient registration before visit
    - Bill patient if no coverage
  - Hospital
    - Bill patient directly, or have the patient attend a nearby registry office to register (AH Bulletin Gen 122)




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**Action Code Uses**

- A (add)
  - Use for new claim or claim that was refused and is being resubmitted
- C (change)
  - Use to change information on a claims that has been applied
  - Cannot be used to change PRACID, BA, ULI
- R (reassess)
  - Use to resubmit applied claim paid at "0" or reduced
  - Must have text; may not change any of the data fields
- D (delete)
  - Use to delete a claim that was paid in full, reduced or applied at "0"




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**35K – Pay to code**

- Pay to code indicates pay to physician, or pay to patient (default is pay to physician)
- Is invalid or cannot be changed
  - Caused by:
    - Trying to change a pay to patient to pay to practitioner or vice versa
    - Also caused by pay to patient claim when patient is ineligible for AHCIP



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**39DA – Facility number**

- Is invalid or blank
- Facility listing
  - Be sure you're using most recent (January 2021 is latest )
  - <https://open.alberta.ca/publications/alberta-health-facility-and-functional-centre-definitions-and-facility-listing>
- Practice moved and didn't apply for a new facility number
- LTC facility changed status to designated living



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**39EB – Diagnostic code**

- Diagnostic code is invalid or blank
- All claims require diagnostic code with exception of:
  - Anesthetic services
  - Surgical assist service
  - Diagnostic imaging
  - Time premium codes (03.01AA)
- If diagnostic codes added for exceptions AHW will validate

NOTE: Although convenient, using 780 for all can cause later problems  
E.g. WCB claim refusals if patient is being treated for WCB injury in addition to insured service



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**Why not use 780?**

- Using 780 can impact HQCA reporting that allows reporting and indication of burden of disease and chronicity in patient population
- It can impede AMA ability to cost proposed changes to the Schedule
- Level of detail gained through good diagnostic reporting can improve:
  - Your panel management
  - Your WCB claims assessment (because WCB/AH data comparison will cause codes to reject)
- Risks in using non-specific diagnostic codes include later reassessment by AH to recover visits they say are WCB's responsibility



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**39EC – HSC/diagnostic code conflict**

- All procedural codes (M, M+, Categories 1 –15)
  - restricted to specific diagnostic codes
- Most visit services (V) not restricted
  - Exception: psychiatric services
- Notify AMA or AHW if you feel code applicable



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**39G – Modifier code**

Modifier code is:

- Is required – and not in the claim
- Is invalid
- Can only have one modifier of same type
  - E.g., CMGP01, CMGP01
- Can not have this combination of modifiers
  - ANE & SA
- Must have 2 digit numeric suffix
  - TEV02 vs TEV2
- Exceeded the maximum time units allowed
  - e.g., claimed >10 CMGP units



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**Modifier Types (examples)**

- Implicit – Do not have to add to claim
  - Tray service – payment is based on location of service (pays in office, not hospital)
  - Age – some services are paid at different rates based on patient age (03.03A for pts 75+)
- Explicit – must add to claim (examples)
  - Complexity modifiers
    - CMGP01-10, CMXV15, 30; CMXC30; COINPT



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**60 – Initial visit - major**

- A second major visit within 180 days of the last one (GR 4.6)
  - Resubmit with an 03.03A or applicable repeat/minor consultation (03.07A, 03.07B)
  - Remember complex modifiers if applicable
  - Exception:
    - 90 days for comprehensive visit or consultation & 03.04B (initial prenatal visit)
    - 90 days for 03.08A for children under 1 year
  - Edit check is per physician / per patient



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**Questions?**

**Please raise your hand**



Click the Raise Hand emoji if you would like to ask a question out loud. Your Zoom window will move up to the front of the gallery if your hand is raised.



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Virtual Care Billing Codes




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Virtual Care

- **7 new billing codes for virtual services during the pandemic; 3 most relevant to family medicine**
  - Not subject to daily cap on office visit services
  - Similar to existing codes, but some differences
  - Must be initiated by patient
    - How? Request for appointment, call to discuss problem, referral for consultation, part of ongoing follow-up care/treatment for illness/condition, etc.
    - Physician may not solicit the visit by cold calling, but panel management OK
  - For example...

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Virtual Care

- Time/other requirements
  - Physician:Patient contact time only; no other time may be included
  - 03.01AD <10 minutes
  - All other codes – at least 10 minutes, or other noted time requirement
  - Start/stop times must be part of detailed patient record
  - Must be patient driven (request, previous appointment or consultation request, part of ongoing course of care), or...

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**Virtual Care**

- Premiums and modifiers
  - No complexity modifiers (CMGP, CMX series)
  - Business Cost and Rural Remote Northern not available
- Limitations
  - May claim only one virtual care or in-person service on the same day; no add'l visit services
  - Not for general information about COVID-19

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**Virtual Visits**

- 03.01AD
  - <10 minutes direct contact by phone, videoconference, or asynchronous email response to patient
  - Includes prescription renewal or new prescription (no add'l 03.01NM)
- 03.03CV (virtual 03.03A)
  - 10 + minutes direct contact, phone or video
  - Limited assessment of problem, advice to patient, record (including start/stop time)

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**Mental Health**

- Scheduled telephone/secure videoconference for psychiatric treatment:
  - 08.19CW – Family Med and Pediatrics (/full 15 minutes)
  - Includes medical psychotherapy, medication prescription, reassessment, patient education and/or counseling, including group therapy
  - May also be used for palliative care
  - Direct physician:patient time only
  - Detailed record, including start/stop times
  - Not claimable with other virtual/in-person visits same day (same patient)
  - Patient must have established hx requiring service

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### Virtual Care Principles

- Billing rules haven't changed and follow established rules for in-person visits
- Only physician:patient direct interactions claimable
- Patient-initiated visit can include:
  - A patient-initiated appointment regarding a new problem
  - Consultations and clinically-necessary follow-up of an ongoing condition or previously initiated treatment plan
  - Direct patient contact resulting from panel management to ensure chronic and high-needs patients receive appropriate care
  - Physician:patient contact following referral by AHS screening program (including COVID-19)

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### Virtual Care Examples

- Virtual care of high-risk/high-needs patients in physician panel, following ID through panel management, including:
  - Socially isolated/frail elderly
  - Long-term care patients
  - Chronic disease, including significant mental health
  - Complex pediatric patients

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### Virtual Care Examples

- Contact with elderly/high-risk patients at request of hospital or zone medical leaders to discuss goals of care
  - In the event the patient contracts COVID-19 in future
  - If the patient currently has COVID-19
- PCN/clinic staff may initiate call, but only physician:patient direct time is claimable

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**Questions?**

**Please raise your hand**



Click the Raise Hand emoji if you would like to ask a question out loud. Your Zoom window will move up to the front of the gallery if your hand is raised.



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**In-person Visits**

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**Limited/Brief Visits**

- The extent of examination of the patient and presenting problem guide which visit or consultation to claim:
  - Limited Assessment/Consultation (03.03A, 03.03AZ, 03.07A, AZ)** – examination and history focused on the presenting problem (eligible for CMGP modifier).
  - Prenatal Visit (03.03B, 03.03BZ)** – eligible for CMGP modifier
  - Brief assessment (03.02A)** – minimal history, little or no physical examination (no modifiers).

Remember, 03.03A has an additional premium of 20% for patients 75 and older

For mask exemption requests claim appropriate visit to assess and bill patient for form completion



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### Minor and Repeat Consultations

- **03.07A, 03.07AZ (Minor Consultation)**
  - Problem-focused examination and history, **OR**
  - Have claimed a major consultation in last 365 days and patient re-referred for different problem
- **03.07B (Repeat Consultation)**
  - Patient re-referred for same problem as previous consultation
- Both eligible for CMGP modifiers
- Must meet consultation requirements



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### Complex Care – Family Practice

CMGP	Complex patient consultation/visit – first FULL 15 minutes and then in FULL 10 minute increments to a maximum of 10 units	\$18.48 ea
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- Complex patient requiring that physician spend 15 minutes or more on management of patient care
- Second & subsequent units only billable when full 10 minutes has elapsed
- What does this mean?
  - 10 minute patient direct contact + 6 minute conversation with diabetic educator + 10 minutes writing referral letter to ortho = 03.03A (office visit) plus CMGP02 modifier



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### Complex Care – Family Practice

Visits and Consultations eligible for CMGP modifier	
03.01J	Assessment of an unrelated condition in association with a Workers' Compensation service
03.03A 03.03AZ	Limited assessment of a patient's condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient
03.03B 03.03BZ	Prenatal visit
03.03C	Routine post-natal office examination



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### Complex Care – Family Practice

Visits and Consultations eligible for CMGP modifier	
03.03N	Home visit - first patient
03.03Q	Home Visit – repeat home visit same day
03.03NA	Home visit to patients residing in Assisted Living, Designated Assisted Living (DAL), group homes, seniors lodges or personal care home, first patient
03.03NB	Home visit to patients residing in Assisted Living, Designated Assisted Living (DAL), group homes, seniors lodges or personal care home, first patient
03.07A 03.07AZ	Minor consultation (only GP skill code)
03.07B	Repeat Consultation (only GP skill code)



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### Using CMGP

- Definition:** Complex patient visit requiring 15 minutes or more physician time re clinical work(direct, indirect)
  - Indirect includes review of diagnostics, charting, drafting referral letter, etc., as long as done on same date as patient visit.
- Office visit – 15 minutes (including direct patient time and charting done after clinic hours)
  - 03.03A with modifier CMGP01
- Office Visit – 15 minutes direct patient care; 20 minutes coordinating referral to community support, charting
  - 03.03A with modifier CMGP03

**Billing Tip:**  
Time for reviewing diagnostics, labs or charts can be included in complexity time if you saw the patient on the same date



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### Comprehensive Visits

- 03.04A (Comprehensive Office Visit); 03.04AZ (Comprehensive Visit, outside of office)**
  - For family practice this is complete head-to-toe, all systems (GR 4.1)
  - Not payable more often than once every 365 days/ patient/physician (20 day buffer; includes 03.04A, AZ, CV, 03.08A,AZ, CV)
  - Must include a care plan (NEW March 31, 2020)
  - CMXC30 eligible when 30+ minutes
- 03.04B (Comprehensive Prenatal Visit)**
  - Not within 90 days of comprehensive visit
    - Once per pregnancy
    - Includes full history, examination, initiation of prenatal record
    - CMXC30 eligible



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**Comprehensive Visits**

**Comprehensive Examination Requirement – Rule 4.1:**

In the context of GR 4, complete physical examination shall include examination of each organ system of the body, except in psychiatry, dermatology and the surgical specialties. "Complete physical examination" shall encompass all those organ systems which customarily and usually are the standard complete examination prevailing within the practice of the respective specialty. What is customary and usual may be judged by peer review.



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**Comprehensive Visits**

**Comprehensive Visits and Consultations – Rule 4.2.3**

Comprehensive Visit: An in-depth evaluation of a patient. This service includes the recording of a complete history and performing a complete physical examination appropriate to the physician's specialty, an appropriate record and advice to the patient. It may include the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient. Advice to the patient must include discussion of a care plan related to the patient's condition(s). Patient care advice, including the discussed care plan, must be documented in the patient's record. The care plan does not have to be formally signed by the patient.



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**New Rule – Comprehensive Visit**

**Comprehensive Visit (Rule 4.2.3) additional requirement, now must include:**

- "discussion of a care plan related to the patient's condition(s). Patient care advice, including the discussed care plan, must be documented in the patient's record. The care plan does not have to be formally signed by the patient."
- This new wording impacts requirements for 03.04A
- AH for definition of care plan
  - Must be specific to patient
  - Documented findings and plan for patient
  - Recorded in patient's record

This requirement was implemented by AH when the comprehensive care plan was removed (March 30, 2020)




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**Complex Care Comprehensive Visits**

<b>CMXC30</b>	Complex patient consultation / visit requiring that physician spend 30 minutes or more on patient care and management of patient care (only one claimable) on same date seen	\$31.43
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**Complex Care cont'd**

Visits and Consultations eligible for CMXC30 modifier	
<b>03.04A, AZ</b>	Comprehensive visit
<b>03.04B</b>	Initial prenatal visit
<b>03.04C</b>	Hospital admission
<b>03.04D</b>	Long term care admission (Nursing Home/Auxiliary Hospital or a long term care bed in a general hospital)
<b>03.04E</b>	Emergency home visit and admission to a hospital and hospital visit on the same day
<b>03.04M</b>	Pre-operative history and physical examination in relation to an insured service
<b>03.08A, AZ</b>	Comprehensive Consultation



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**Activities that Contribute to CMX**

- Complexity is solely determined by time (No requirement for multisystem disease)
- Services to include in calculation of time when on same date as patient seen:
  - Review of patient chart prior to seeing patient
  - Talking to & examining patient
  - Charting
  - Review of any lab or DI investigations
- Exclude time for another billable service (e.g. 13.99BA) in the calculation of CMX
- In case of a consultation time for dictation of referral or consultation letter
- **NOTE: No non-physician time (including intern/resident/nursing time) may be included**



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### Visits vs. Consultations

- Consultations may only be claimed when ALL of the following criteria have been met:
  - Patient is examined by referring provider (full list G.R. 4.4.1)
  - Referring provider specifically requests (verbal or written) opinion and or advice of consultant
- Consultant performs:
  - full history (03.08A) or problem-focused history (03.07A or B), and
  - full physical (03.08A) or problem-focused history (03.07Aor B), relative to their specialty
  - may order lab or diagnostics
  - discusses treatment and advice with the patient and in some cases the referring provider
  - provides referring provider with written report about recommendations, treatment, opinion.
- Criteria not met? **It's not a consultation**




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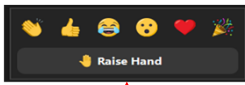
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### Questions?

Please raise your hand



Click the Raise Hand emoji if you would like to ask a question out loud. Your Zoom window will move up to the front of the gallery if your hand is raised.




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### Billing Specifics

Family Conferences/Other Indirect Services to/Communication with Patients





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### Family Conference via Telephone

03.05JP	Family conference via telephone relating to acute care facility in-patient, registered ER or out-patient, LTC, hospice patient UCC or AAAC patient	\$41.20
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- Intended for patients who are unable to communicate or require periodic family conferences
- Location or mobility factors preclude meeting in person
- Timely communication with family is essential to patient care or organ/tissue transfer/collection
- Communication about patient condition or to obtain collateral information relative to patient management and care activities
- Not claimable** for relaying lab or DI results or arranging follow up care
- Documentation of communication to be maintained in patient record



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### Family Conference via Telephone cont'd

03.05JH	Family conference via telephone in regard to a community patient	\$18.92
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- Claimable when:
  - Location or mobility factors preclude meeting in person
  - Communication about patient condition or to obtain collateral information relative to patient management and care activities
    - May be claimed in pre- and post-operative periods
    - Not claimable for relaying lab or DI results or arranging follow up care
    - Documentation of communication to be maintained in patient record



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### Family Conferences via Telephone cont'd

03.05JQ	Family conference with relative(s) via telephone in connection with management of patient with a psychiatric disorder	\$51.98
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- Claim using the patient's health number
- When notifying of mental health crisis and family is not able to attend in person and timely communication is required or family must be immediately notified
- Do not claim for relaying lab or diagnostic results or gathering CTO information
- Not for follow-up care
- Retain documentation of communication and relationship of family member (e.g. spouse, sibling, parent)
- May be claimed in addition to other visits on same day



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### Family Conferences – in person

<b>03.05IB</b>	Formal scheduled family conference /15 min or major portion thereof	\$51.98
<ul style="list-style-type: none"> <li>Use when discussion with family scheduled in advance</li> <li>Claim using the patient's health number</li> <li>With para medical personnel re: health care where social &amp; other issues involved</li> <li>More than one physician – text required</li> <li>Max 3 hrs/year/patient/physician</li> </ul>		
<b>03.05JC</b>	Family conference relating to acute care facility inpatient or registered emergency or outpatient, auxiliary hospital or nursing home patient, AACC or UCC patient (per 15 minutes or major portion thereof)	\$42.47
<ul style="list-style-type: none"> <li>Claim using the patient's health number</li> <li>Max 3 hrs/year/patient/physician</li> <li>Intended for patients whose condition warrants periodic family conferences</li> <li>Not intended for bedside discussions with patient family</li> </ul>		



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### Team Conferences

<b>03.05JA</b>	Formal, scheduled, multiple health discipline conference /15 min or major portion thereof	\$42.47
<ul style="list-style-type: none"> <li>With para medical personnel re: health care where social &amp; other issues involved</li> <li>Not intended for review of physician panel, giving patient care direction to PCN or office staff, including referral coordination, appointment follow-up and so on</li> <li>Must be booked to discuss specific individual patient, and</li> <li>Discussion regarding individual patient must be 8 minutes or more to claim</li> <li>More than one physician attending to discuss individual patient – text required</li> <li>Max 3 hrs/year/patient/physician (April 1 – March 31)</li> <li>Not billable at same encounter as visit</li> <li>Not claimable for giving care instructions to office/hospital staff</li> </ul>		



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### Physician Call to Patient

<b>03.05JR</b>	Physician telephone call directly to patient, to discuss patient management/diagnostic test results	\$20.00
<ul style="list-style-type: none"> <li>Max 14/week/physician (Sun – Sat)</li> <li>May not be used for INR management</li> <li>Not claimable for same patient in the same calendar week as 03.01S or 03.01T</li> <li>BUT... may be claimed on same date as in-person visit with patient             <ul style="list-style-type: none"> <li>Be sure to use a different encounter number for the phone call</li> <li>E.g. visit – encounter 1; phone call – encounter 2</li> </ul> </li> </ul>		



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### E-Communication to Patient

<b>03.01S</b>	Physician to patient secure electronic communication	\$20.00
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- Only claimable:
  - For medically necessary advice or follow-up where the condition can be managed safely via electronic communication
  - Secure electronic communication in compliance with CPSA guidelines
  - Physician/clinic has submitted a Privacy Impact Assessment acceptable to the OIPC
  - Physician has an established physician/patient relationship and has seen patient within previous 12 months
  - Physician & patient must have previously discussed & agreed to limitations of health management using electronic means
  - Electronic communication must alert patient if physician not available
  - Max 1/patient/week to max 14/week/physician
  - Visit not billable within 24 hours of e-communication
  - Only 1 of HSCs 03.05JR, 03.01S, or 03.01T/patient/physician/week
  - Documentation must be recorded in patient record
  - **Not claimable** for inpatients
  - **Not claimable** when provided by physician proxy

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### Videoconference with Patient

<b>03.01T</b>	Physician to patient secure videoconference	\$20.00
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- Only claimable:
  - For medically necessary advice or follow-up where the condition can be managed safely via secure videoconference
  - Service provided using a secure videoconference system in compliance with CPSA guidelines
  - Physician/clinic has submitted a Privacy Impact Assessment acceptable to the OIPC
  - Physician has an established physician/patient relationship and has seen patient within previous 12 months
  - Max 1/patient/week to max 14/week/physician
  - Visit not billable within 24 hours of e-communication
  - Only 1 03.05JR, 03.01S or 03.01T/patient/physician/week
  - Not claimable for inpatients
  - Documentation must be recorded in patient chart
  - Not claimable when provided by physician proxy

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### Phone Call – INR

<b>03.01N</b>	Management of anticoagulant therapy	\$17.43
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- 2/month/patient
- Claimable only if advice re: dosage given
- Must be documented
- Includes:
  - Ordering blood tests
  - Interpreting results
  - Adjusting dosage as required
- Not payable for hospital in or out patients

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**Billing Specifics**  
Telephone/Other Communication with Physicians/Other Professions




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**Phone Advice**

- Phone advice to paramedic, assisted living/designated living and lodge staff, active treatment facility worker (in patient), long term care worker, nurse practitioner, hospice worker, home care worker or public health nurse via telephone or other telecommunication method
  - Different rules for each
  - Resident physicians are not considered active treatment facility staff
  - Claimable for inpatients/LTC patients, but not ER patients

Claim when instructions re patient care and management are given via telephone at request of facility or home care staff. If call results in physician attending patient in person, claim appropriate visit with time premiums/inconvenience codes or modifiers.

03.01NG	W/D 0700 – 1700	\$17.43
03.01NH	W/D 1700 – 2200 or W/E 0700 – 2200	\$20.60
03.01NI	ANY DAY 2200 – 0700	\$23.77



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**Rules for Phone Advice**

- Must be initiated by other party
  - Except LTC – may be physician initiated
- Maximum 2/patient/physician/day
- May be claimed in addition to other services SDOS
- Documentation required
- LTC & Active Rx worker – physician must be outside the facility
- Location is where physician is (HOME, OTHR, office)
- Nurse practitioner – must be in independent practice or working at nursing station with no physician present
- Home care – may be in person & must be administered by AHS



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### Advice to Pharmacist

<b>03.01NM</b>	Patient care advice to a pharmacist provided via telephone or other telecommunication methods in relation to the care and treatment of a patient	\$17.43
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- **Purpose:** To seek advice/opinion or to inform physician when changes to prescription, pharmacist initiated prescriptions, care plans or med reviews have occurred.
- Pharmacist must initiate
- **Not claimable for/when:**
  - Prescription renewal
  - Physician proxy provides advice
- Max 1/day/patient; multiple patients discussed, each billable
- Visits billable in addition
- Documentation required in patient record



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### Physician to Physician Telephone or Telehealth Videoconference or Secure Videoconference Consultation

Referring Physician (must be practicing physician – not resident)		
<b>03.01LG</b>	W/D 0700 – 1700	\$33.28
<b>03.01LH</b>	W/D 1700 – 2200 or W/E 0700 – 2200	\$36.45
<b>03.01LI</b>	2200 – 0700	\$40.69
Consultant (must be practicing physician – not resident)		
<b>03.01LJ</b>	W/D 0700 – 1700	\$77.74
<b>03.01LK</b>	W/D 1700 – 2200 or W/E 0700 – 2200	\$115.07
<b>03.01LL</b>	2200 – 0700	\$135.81



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### Physician to Physician Telephone or Telehealth Videoconference or Secure Videoconference Consultation

- **Claimable when:**
  - Call initiated by referring physician (not resident)
  - Consultant (physician, not resident) provides opinion & recommendations for pat Rx & management
  - Service provided using a secure videoconference system in compliance with CPSA guidelines
  - Physician/clinic has submitted a Privacy Impact Assessment acceptable to the OIPC
- **Not claimable when purpose of call is to:**
  - Arrange for transfer within 24 hours unless patient transferred to an outside facility and advice was given re management prior to the transfer
  - Arrange for an expedited consultation or procedure within 24 hours
  - Arrange for lab or DI investigations
  - Discuss or inform referring physician of results of diagnostic information
- Max 2/day/patient/physician – documentation required
- Telehealth videoconference both physicians must be at regional telehealth facility
- Referral PRACID required



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**E-Consultations**

03.01R	Physician to physician e-consultation – referring physician	\$33.28
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- Time spent completing the referral may **not** be claimed using complexity modifiers
- Documentation of the request and advice given must be recorded in patient record
- **Claimable when:**
  - Request and response are sent using a secure electronic communication that is in compliance with CPSA guidelines on secure electronic communication
  - Physician/clinic has submitted a Privacy Impact Assessment acceptable to the OIPC
- **Not claimable when/with:**
  - Arranging for an expedited consultation
  - Arranging for lab or DI investigations
  - Discussing or informing referring physician of results of diagnostic information
  - For transfer of care
- NetCare eConsultation service eligible



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**E-Consultations cont'd**

03.01O	Physician or nurse practitioner to physician secure e-consultation – consultant	\$68.65
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- Requires referral PRACID
- Request and response must be recorded in patient record
- **Claimable when:**
  - Request and response are sent using a secure electronic communication; in compliance with CPSA guidelines
  - Physician/clinic has submitted a Privacy Impact Assessment acceptable to the OIPC
  - Consultant provides opinion/advice &/or recommendations for pt Rx &/or management within 30 days of request
  - Request initiated by referring physician
- **Not claimable when/with:**
  - Major consult, physician to physician phone call, procedure for same condition within 24 hours unless patient transferred to an outside facility and advice was given re management prior to the transfer
  - For transfer of care
  - Arranging for an expedited consultation or procedure within 24 hours
  - Arranging for lab or DI investigations
  - Discussing or informing referring physician of results of diagnostic information



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**Procedures**  
 Minor Procedures (M)  
 Minor Diagnostic Procedures (M+)

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### Visits with Procedures

- Minor procedure (M) and office visit
  - Both payable if unrelated Dx code
  - Procedure includes removal of sutures
    - Same physician
    - Same practice group
  - Local infiltration included in the benefit

If billing counselling plus procedure, be clear in your records the different diagnoses, and exclude procedure time from counselling time (as you would do for CMGP time)




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### Visit & Procedure Exceptions Billable at same Encounter

10.16A	Pessary fitting
10.16B	Pessary removal, adjustment and/or reinsertion (not claimable with 10.16A)
81.8	IUD insertion
11.71A	Removal of intrauterine contraceptive device (IUD)
13.59A	IM or subcutaneous injections
13.59O	Injections for Botulinum A Toxin for the prophylaxis of chronic migraine headaches
13.99BA	Periodic Papanicolaou smear
13.99BE	Pelvic examination using a speculum requiring swab(s) and/or sample(s) collection
13.99BD	Anal Papanicolaou smear




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### Visit & Procedure Exceptions Billable at same Encounter

16.81A	Spinal tap
51.92A	Varicose vein injection
58.99F	Manual disimpaction of stool
79.22	Cautery of cervix
79.23A	Cryotherapy of cervix
93.91A	Joint injection, hip
93.91B	Joint injection other joints
98.03A	I&D of abscess or hematoma, subcutaneous or submucous
98.12L	Rx of warts
98.12C	Removal of sebaceous cyst
98.12J	Removal or excision (warts, keratoses)




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**Diagnostic Surgical Procedures(+)** (GR 6.6)

- Office
  - “+” and visit – both payable
  - “+” and consultation – both payable
- Hospital
  - “+” and visit – greater only
  - “+” and consultation – both payable



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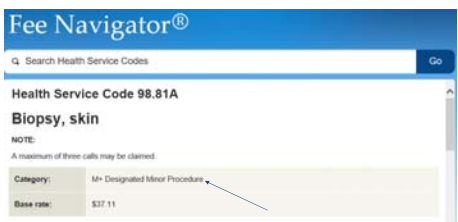
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**Diagnostic Surgical Procedures**



**Fee Navigator®**


Search Health Service Codes

**Health Service Code 98.81A**

**Biopsy, skin**

NOTE:  
A maximum of three calls may be claimed.

Category:	M- Designated Minor Procedures
Base rate:	\$37.11



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**Treatment of Warts**

- Treatment of warts is uninsured except for:
  - genital warts
  - plantar warts
  - precancerous skin lesions, e.g. actinic keratoses; seborrheic keratoses, which are irritated and treatment is medically required
  - warts in immuno-deficient patients
  - immuno-suppressed patients
  - molluscum contagiosum



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### Removal Foreign Body

12.01	Removal of intraluminal FB from nose (M)	\$47.54
12.21	Removal of intraluminal FB from ear (M)	\$47.54
12.23	Removal FB from vagina (M+)	\$86.82
12.24	Removal FB from urethra (M)	\$121.11
12.31	Removal of non-penetrating FB from eye w/o incision (M)	\$38.03
25.1A	Removal of FB from cornea (M)	\$40.58
98.04A	Removal FB skin or subcutaneous tissue; under anesthesia (M)	\$39.36
98.04B	Removal FB skin or subcutaneous tissue; without anesthesia (M)	\$23.45

If you have the choice of billing either a visit OR a minor procedure:

In the office:

- Bill both the procedure and visit if the visit plus any applicable modifiers would pay more (why? tray fee)
- If the procedure pays more



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### M Cat Procedures and Visits – Same Encounter

- In general, minor procedures and visits won't pay at the same encounter
- Some have a permissive note indicating they may be claimed with a visit (e.g. 13.99BA)
- If you have the choice of billing either a visit OR a minor procedure:
  - In the office: bill both the procedure and visit if the visit plus any applicable modifiers would pay more (why? You'll want the tray fee)
  - In an AHS or Covenant facility: claim the greater of the visit or procedure, but not both
- If the procedure pays more, bill the procedure



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### Major Procedures – Pre- and Post-Op Care

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



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**BMI Modifier**

- Pays an additional 25% for
  - BMI of 40 or greater or pediatric greater than 97 percentile
    - Applicable to selected procedures provided in any location (including office, ER, etc.)
    - 13.99BA – pap smear
    - 13.99BE – pelvic exam using speculum requiring swab(s)/sample(s)



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**Emergency Services**

13.99J	Medical emergency detention time, per 15 minutes or major portion thereof	\$60.22
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- Personally & continuously attend and treat an illness or injury of an emergency nature
- Text required
- Time based / 15 minutes / cumulative
- Not for standby or spending a long time with a patient
- Maximum of 8 per day, per physician in office
- Maximum of 16 per day, per physician other than office
- May be claimed at same encounter as visit – visit is then first 30 minutes or contact
- May be claimed at different encounter than visit on same date



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**Pronouncement of Death (GR 4.15)**

- Specifically called and attended on a priority basis – bill as appropriate visit
- No benefit for a certificate of death



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**Billing Specifics**  
Other Visits and Patient Care




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**Psychotherapy (08.19G)**

<b>08.19G</b>	Direct contact with an individual patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or general psychiatric counseling	\$47.54
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- **NON-PSYCHIATRIST - only when physician assessment establishes that patient is suffering from psychiatric disorder**
- Time based; claim per 15 minutes or major portion thereof
- Claim for direct physician:patient time



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**Palliative Care**

Definition: Terminal Disease, Multidisciplinary Team (GR 4.2.4)

<b>03.05I, 03.05IZ</b>	Direct care	\$52.32
	<ul style="list-style-type: none"> <li>• Per 15 min or portion thereof</li> <li>• No current modifiers for after-hours</li> </ul>	
<b>03.05T</b>	Indirect care	\$42.47
	<ul style="list-style-type: none"> <li>• Per 15 min or major portion thereof</li> <li>• Essentially a team conference with other physicians, family, allied health, community agencies</li> <li>• Bill under patient ULI</li> </ul>	
<b>03.05U</b>	Second physician at palliative care conference	\$28.53
	<ul style="list-style-type: none"> <li>• Per 15 min or major portion thereof</li> </ul>	



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### Admission to Addiction Rx Facility

<b>03.04I</b>	Comprehensive visit, including completion of form, required for admission to an regional health authority addiction residential treatment facility	\$123.61
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- Only for AHS-operated facilities
  - See this link: <http://www.humanservices.alberta.ca/AWonline/IS/4873.html>
- Admission forms to others are uninsured and should be billed to the patient/3<sup>rd</sup> party

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### Pre-op H & P

<b>03.04M</b>	Preoperative history & physical in relation to an insured service	\$104.60
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- NOTE: 03.04M CMXC30 applicable**
  - Included in surgical benefit if same physician provides both
  - Claimable when an examination and standard form for pre-op assessment have been completed**
  - Copy must be maintained in patient's chart
- Pre-op for dental only insured if anesthetic insured**
  - Severe mental or physical disability precludes performance under local
  - Dental service is insured under dental benefits regulations
  - Presence of disease adds risk to organ transplant or open cardiac surgery or patients with compromised immune system
  - Child 17 or under requires extensive dental rehabilitation

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### Capacity Determination

<b>03.04N</b>	Comprehensive evaluation including completion of forms to determine capacity as defined by the <i>Personal Directives Act (PDA) (RSA 2007 s9(2)(a)</i>	\$193.34
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**NOTE:**

1. Benefit includes witnessing the agents' or service providers' assessment.
2. May be claimed to determine lack of capacity or to determine that capacity has been regained.

See this link for Guide: <https://open.alberta.ca/dataset/a86649cc-b0d4-44bb-ab0a-ee8609f29f4/resource/9ff4213f-84b6-4f08-bbcf-05497b5a6017/download/opg-guardianship-publication-opg5630.pdf>

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### Home Visits

03.03N	Home visit, first patient seen	\$85.58
03.03P	Home Visit, second and subsequent patients seen	\$31.70

- Must complete a limited assessment of a patient's condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient to claim
- "Home" includes personal residence or temporary lodging, group home, seniors' lodge, personal care home and other residences as approved, but does not include auxiliary hospitals or nursing home
- CMGP eligible – include clinical time, charting, care coordination, etc., but not travel time



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### COVID Vaccinations and Vaccination Counselling

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### COVID-19 Vaccinations

Code	Description	Rate
13.59V	Immunization and Administration of COVID-19 Vaccine	\$25.00

- Purpose of visit is COVID vaccination; claim 13.59A + 03.03A if visit for another purpose
- Includes determination of eligibility; review of NetCare/other information system
- Discussion with patient, parent/guardian, agent re risks/benefits
- Obtaining consent, administering vaccine, monitoring for immediate adverse effects
- Updating patient's immunization record (Immunization Direct Submission Mechanism) -- ++ fines if not updated
- Creating own physician record, and reasonable follow-up with patient re second dose

May be claimed when

- Physician administers vaccine themselves
- Physician is on-site and immediately available when vaccine is administered by a member of physician's office team.



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### COVID-19 Vaccinations

Code	Description	Rate
13.59VA	Prolonged COVID vaccination, physician time only, greater than 10 minutes	\$20.00

- Claim in addition to 13.99VA when physician spends greater than 10 minutes directly with the patient – indirect care not eligible
- Documentation must include:
  - Detailed description of service
  - Any counselling
  - Any adverse reaction to vaccine
  - Start and stop times for all direct patient care time by physician
- Not for post-vaccination monitoring of patient
- No claims for concurrent/overlapping times
- Not claimable in addition to other services during same encounter for same patient.

May be claimed when

- Physician administers vaccine themselves
- Physician is on-site and immediately available when vaccine is administered by a member of physician's office team.



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### COVID-19 Vaccination Counselling

Code	Description	Rate
03.01CC	Telephone advice/counselling to patient or legal guardian regarding COVID-19 Vaccine	\$20.00

- Temporary Code to support vaccine uptake.
- All physicians eligible to claim when contacting own patients by telephone to counsel those who have not had first vaccination
- Physician or qualified member of staff must determine patient eligibility in advance of call (NetCare)
- Claimable if call does not result in vaccination appointment or vaccination
- Claimable with COVID vaccination or prolonged vaccination codes (13.99V or 13.99VA) same date – no other services
- Use diagnostic code 079.8 or 079.82

May be claimed when

- Physician:patient direct contact
- Patient has not had first COVID-19 vaccination (check NetCare)
- Patient is counselled re vaccination



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## Questions?

Please raise your hand



Click the Raise Hand emoji if you would like to ask a question out loud. Your Zoom window will move up to the front of the gallery if your hand is raised.



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Resources




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Monitoring

- Physicians are responsible for all claims submitted
- Paid does not always mean it was legitimate
- There are some edits in place to catch obvious errors
- If in doubt, check it out:  
[billingadvice@albertadoctors.org](mailto:billingadvice@albertadoctors.org)



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Monitoring cont'd

- In the office, compare:
  - Appointment log to submissions
  - Submissions to statement of assessment
- Review statements of assessments or reconciliation report from billing software
- Do explanatory codes make sense?
- If not ask...
  - AMA – billing advice or individual
  - AH



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**Resources**

- AMA Fee Navigator®
  - [www.albertadoctors.org/fee-navigator](http://www.albertadoctors.org/fee-navigator)
- AMA Billing Advice
  - [billingadvice@albertadoctors.org](mailto:billingadvice@albertadoctors.org)
- Alberta Health Bulletins
  - [www.alberta.ca/bulletins-for-health-professionals.aspx](http://www.alberta.ca/bulletins-for-health-professionals.aspx)
- Alberta Health Schedule of Medical Benefits
  - <https://www.alberta.ca/fees-health-professionals.aspx>



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**Questions and Wrap-up**

**Please raise your hand**



Click the Raise Hand emoji if you would like to ask a question out loud. Your Zoom window will move up to the front of the gallery if your hand is raised.



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**Polling**



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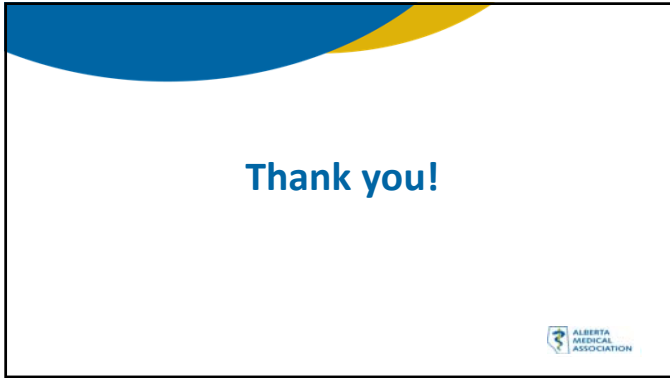
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