AMA Billing Seminar
CWC PCN Virtual Care
In-Office Visits and Procedures

April 21, 2022

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AMA Fees Consultant

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Session Overview

- ❑ Virtual and Office Visits
- ❑ Physician to Physician communication
- ❑ Palliative Care and Psychotherapy (virtual and in-person)
- ❑ Procedures in the office
  - ❑ Common procedures
  - ❑ On same day as visit

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Billing Specifics

Overarching Rules, etc.

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Stay up-to-date

- Read the AMA's Billing Corner and AH Bulletins
- Use the AMA Fee Navigator™
  www.albertadoctors.org/feenav
- Download and review the Schedule components:
  http://www.health.alberta.ca/professionals/SOMB.html
- Remember – Physicians decide what fee code, and how many, to bill!

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Need Help?

- Alberta Health Resources
  - Physician Resource Guide
  - Schedule of Medical Benefits Procedure List
- Alberta Health
  - 310-0000 780 422-1600
  - Email: Health.HCIPAProviderClaims@gov.ab.ca
- AMA – Physician Advocacy (AMA members)
  - 1-800-272-9680 780 482-2626
  - E-mail:
    billingadvice@albertadoctors.org
    norma.shipley@albertadoctors.org
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Verifying Coverage

- IVR 1-888-422-6257/Netcare
  - All new patients, those not seen recently, life change (young adult, change in marital status)
  - Check date of coverage; if not covered, you may bill directly
  - For patients seen in AHS facilities who don't have health insurance, there is support to register: https://www.albertahealthservices.ca/about/Page13445.aspx
- Opted out
  - A few Albertans have formally opted out of health care insurance
  - Bill directly – not limited to Schedule rates
- **Be aware: Alberta Health does not research patient health numbers**

Alberta Health no longer researches or assists with patient coverage questions – be sure you're checking patient coverage in office so you can bill patient directly if they don't have coverage. Encourage patients to go to the local registry office to sort out any problems; when they return with valid documentation, you can refund and bill AH (within 90 days).

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Submission Deadlines (GR 2.7.4)

- 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 (we believe, and will confirm with AH)

- 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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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 notebook, Excel, app in your electronic device
  - Exclude any time for breaks
  - Include any time you spent before or 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 physicians' direct, in person, 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 – physician must be directly supervising
  - Physician to physician and other health professional listed communications
  - Virtual care/other listed indirect physician:patient communication or physician:patient family communication

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Immunizations

Physicians may claim for COVID-19 vaccinations they or their qualified staff provide to patients in their offices (13.59V)

- **Covered by AH:**
  - Flu, COVID-19, Pneumococcal vaccines – physician or qualified health professional in physician office
  - Tetanus – for wound management – physician only
  - Childhood immunizations – physician only
    - Only for pre-existing conditions with potential for severe risk of complications
- All other insured injections must be given by the physician
- **Not covered:**
  - Travel immunizations
  - Gardasil
  - Hepatitis

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Encounter – Definition (GR 1.14)

- Each separate and distinct time a physician provides services to a patient in a given day (defined as 0001 to 2400)
- Not continuation of an earlier service
- Examples:
  - Visit, sent for Dx (lab, imaging) returns same day = one encounter
  - Visit, treatment initiated, patient returns later same day, problem worse or new problem = 2nd visit is encounter two
  - Patient ER visit – all care is same encounter unless patient discharged from ER and returns
  - Virtual care
    - One virtual care service claimable per day
    - Not claimable same date as in-person service

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Encounter – Definition (GR 1.14)

Example	One Encounter	Two Encounters
Visit, sent for Dx (lab, imaging) returns same day	X	
Visit, treatment initiated, patient returns later same day, original problem worse or new problem		X
Hospital inpatient visit, physician returns later in the day to check on patient	X	
Hospital inpatient visit, hospital staff/another physician ask physician to return later in the day on urgent basis		X
Hospital inpatient visit followed by separate family conference or phone call (away from patient bedside)		X

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Questions?

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Billing Specifics

Visits and Consultations

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Virtual Care Billing Codes

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Virtual Care

- **3 billing codes for family medicine virtual services**
  - 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…

Be aware of the privacy requirements for all virtual visits and other services. Review the CPSA Virtual Care Standard of Practice, and check that you have submitted a Privacy Impact Assessment to the AB Office of the Information and Privacy Commissioner

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Virtual Care

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

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Virtual Care Changes January 1, 2022

This is a first step in having longer virtual visits and consultations recognized in the Schedule. More work remains to be done to recognize prolonged visits and consultations.

- Virtual Care changes effective January 1, 2022
- What's new?
  - You can include same-day patient care management time, e.g.
    - Review of chart/diagnostics before seeing patient
    - Care coordination (e.g. confirming referral with MOA, writing referral letter, organizing follow-up care)
    - Charting
    - Writing consultation letter (for 03.08CV only)
  - Limited availability of modifiers
    - CMGP01, no additional calls

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Submitting Claims

- Alberta Health has completed their systems changes and can accept claims for virtual care codes with modifiers as of February 15
- Payment timeline is still 90 days; if you have outstanding claims, submit oldest first

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Virtual Care

- Premiums and modifiers
  - Limited (CMGP01)
  - No Business Cost or Rural Remote Northern payments
- Limitations
  - May claim only one virtual care or in-person service on the same day;
    no add'l visit services other than 03.01NM if initiated by pharmacy
  - Not for general information about COVID-19
  - Have a virtual visit followed by in-person on same date?
    - Consider claiming the in-person visit with additional time modifiers to include the earlier virtual encounter.

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Virtual Visits

- **03.01AD**
  - <10 minutes direct contact PLUS same-day patient care management time by phone, videoconference, or email
  - Includes prescription renewal or new prescription (no add'l 03.01NM unless pharmacy initiates contact)
- **03.03CV (virtual 03.03A)**
  - 10 + minutes direct contact by phone or videoconference, PLUS same-day patient care management time
  - Limited assessment of problem, advice to patient, record (including direct care start/stop time AND time for care management)
  - Add CMGP01 when total direct and same-day patient care management time is 15+ minutes
  - NOTE: WCB uses same virtual codes

NOTE: 03.05JR may be used to follow up on critical test results requiring action. However, it would not be appropriate, for example, to send emails to all patients with positive COVID-19 test results to offer services and claim 03.01AD or 03.01S (note the 03.01S limitation of 14/ physician/ week)

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Virtual Mental Health Visits

- **Scheduled telephone/secure videoconference for treatment of psychiatric illness:**
  - **08.19CW** – Family Med and Pediatrics (per full 15 minutes)
  - Includes medical psychotherapy, medication prescription, reassessment, patient education and/or counseling, including group therapy
  - May also be claimed for direct palliative care and chronic pain care within multi-disciplinary program
  - **Direct physician:patient time only (unchanged January 1, 2022)**
  - Detailed record, including start/stop times
  - Not claimable with other virtual/in-person visits same day
  - Patient must have established hx requiring service

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Virtual Care Principles

- Billing rules are similar to established rules for in-person visits
- Only physician:patient direct interactions PLUS same-day patient care management time 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
  - Physician:patient contact following referral by AHS screening program (including COVID-19)

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E-Communication to Patient

03.01S	Physician to patient secure electronic communication	$20.00

- 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

03.01T	Physician to patient secure videoconference	$20.00

- 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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Using Virtual Care Codes

Using Virtual Care Codes vs. 03.05JR, 03.01S or 03.01T

- Use virtual care codes when contacting patients at their request – e.g.
  - Patient has booked appointment, or
  - Patient has agreed to a follow-appointment or appointments for specific care and a time has been arranged

- Use 03.05JR, 03.01S or 03.01T when
  - The requirements for 03.03CV, 03.08CV or 08.19CW have not been met
  - Physician is initiating contact

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Using Virtual Care Codes

Using Virtual Care Codes when you have multiple patient contacts

- E.g., phone appointment with patient, followed by telephone consultation with specialist colleague, followed by telephone call to patient with advice; all occur on same date

- **Recommendation:**
  - Keep track of time required for patient interactions, and related work for both phone calls
  - Exclude time required for telephone consultation with specialist colleague
  - Claim 03.03CV (note start/stop times of both calls with patient)
  - Add CMGP01 if total time related to both phone calls, excluding physician to physician call is 15 minutes or more that day
  - Claim 03.01LG (referring physician) for the call with specialist colleague (if call occurs between 0700 and 1700; if after 1700, claim 03.01LH)

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Using Virtual Care Codes

- Use virtual care codes when contacting patients at their request – e.g.
  - Patient has booked appointment, or
  - Patient has agreed to a follow-appointment or appointments for specific care and a time has been arranged

- Use 03.05JR, 03.01S or 03.01T when
  - The requirements for 03.03CV, 03.08CV or 08.19CW have not been met
  - Physician is initiating contact

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Using Virtual Care Codes

- **Using Virtual Care for Palliative Care**
  - For virtual palliative care, choose either 08.09CW (per full 15 minutes) OR 03.03CV (with CMGP modifier if appropriate,
  - Use 03.01AD if total time on date is <10 minutes

- **What about a virtual visit, followed by home visit for palliative care:**
- **Option A**: claim either 03.01AD (10 minutes total physician time) or 03.03CV (with CMGP01 where appropriate) for 10+ minutes physician time
- **Option B**: Claim 08.19CW – 1 call per full 15 minutes – this would be better used at the 30 minute + mark of total direct, virtual time with patient
- **Option C**: Claim 03.05I for palliative care visit direct time with patient (total direct, in-person time only) – likely most appropriate for daytime visit of 30+ minutes
- **Option D:** Claim 03.03N (home visit, first patient); use after-hours modifiers if attending within 24 hours of request; claim CMGP modifiers to account for total clinical (but not travel) time, including earlier phone call.

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Questions?

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In-person Visits

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Limited/Brief Visits

NOTE: May be claimed with allowed procedures (e.g., pap smear) on same date.

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

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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

- 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

NOTE: if claiming for an allowed procedure on the same date, exclude procedure consent and work time from visit complexity time. E.g., if doing a pap smear with a visit, exclude time required to prepare patient, and perform pap from your visit complexity time.

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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
- Home Visit – 15 minutes direct patient care; 20 minutes coordinating referral to community support, charting (excluding travel time)
  - 03.03N with modifier CMGP03

Billing Tip:
The full unit of time must elapse in order to claim a unit of CMGP time – e.g. CMGP01 is payable at the 15-minute mark, CMGP02 at the 25-minute mark, etc.

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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)
  - Payable 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 and AZ
- We have asked AH for definition of care plan:
  - Must be specific to patient
  - Documented findings and plan for patient
  - Recorded in patient’s record

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Complex Care Comprehensive Visits

CMXC30	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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Comprehensive Care cont'd

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

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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
  - Physician **must** be outside the facility to claim

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

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.

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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 (use encounter numbers to differentiate if 2 calls made/received)
- 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 (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

03.01NM	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

- **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)		
03.01LG	W/D 0700 – 1700	$33.28
03.01LH	W/D 1700 – 2200 or W/E 0700 – 2200	$36.45
03.01LI	2200 – 0700	$40.69
Consultant (must be practicing physician – not resident)		
03.01LJ	W/D 0700 – 1700	$77.74
03.01LK	W/D 1700 – 2200 or W/E 0700 – 2200	$115.07
03.01LL	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

- 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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Questions?

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Billing Specifics

Family Conferences/Other Indirect Services to/Communication with Patients

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Family Conference via Telephone cont'd

03.05JH	Family conference via telephone in regard to a community patient	$18.92

- 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

03.05JB	Formal, scheduled, family conference relating to a specific patient(per 15 minutes or major portion thereof)	$51.98

- Max 3 hrs/year/patient/physician
- Intended for patients whose condition warrants periodic family conferences
- Not intended for visits where patient is accompanied by family member(s)
- Must be scheduled in advance
- Claim under the patient's health insurance number
- Maintain record of names and family relationships of attendees

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Physician Call to Patient

03.05JR	Physician telephone call directly to patient, to discuss patient management/diagnostic test results	$20.00

- Max 14/week/physician (Sun – Sat)
- May not be used for INR management
- Not claimable for same patient in the same calendar week as 03.01S or 03.01T
- May be

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Phone Call – INR

03.01N	Management of anticoagulant therapy	$17.43

- 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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Questions?

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Billing Specifics

Other Visits and Patient Care

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Psychotherapy (08.19G)

08.19G/GZ	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

- **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 only

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Palliative Care

Definition: Terminal Disease, Multidisciplinary Team (GR 4.2.4)		
03.05I, 03.05IZ	Direct care	$52.32
• Per 15 min or portion thereof • No current modifiers for after-hours		
03.05T	Indirect care	$42.47
• Per 15 min or major portion thereof • Essentially a team conference with other physicians, family, allied health, community agencies • Bill under patient ULI		
03.05U	Second physician at palliative care conference	$28.53
• Per 15 min or major portion thereof		

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Admission to Addiction Rx Facility

03.04I	Comprehensive visit, including completion of form, required for admission to a regional health authority addiction residential treatment facility	$123.61

- 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/3rd party

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Pre-op H & P

03.04M	Preoperative history & physical in relation to an insured service	$104.60

- **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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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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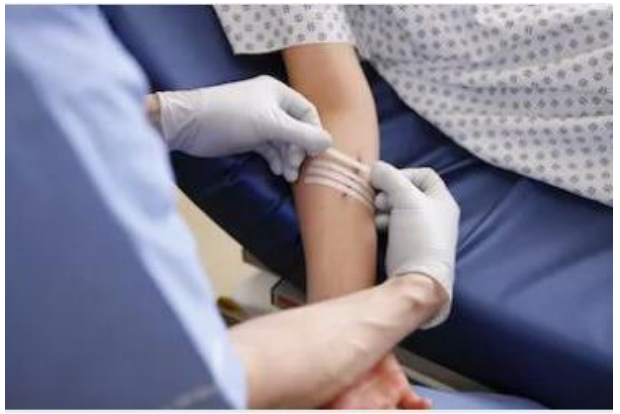
Procedures

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



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COVID-19 Vaccinations

Code	Description	Rate
13.59V	Immunization and Administration of COVID-19 Vaccine (V)	$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, OR
- Physician is on-site and immediately available when vaccine is administered by a member of physician's team who is a qualified health professional.

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COVID-19 Vaccinations

Code	Description	Rate
13.59VA	Prolonged COVID vaccination, physician time only, greater than 10 minutes (V)	$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 spends >10 minutes directly with the patient for any of the described requirements:
  - Counselling patient
  - Care/monitoring re adverse reaction

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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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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
    - A visit may only be claimed if there is another health care reason for it that day
  - If procedure requires sutures to close defect created, they are part of payment
  - Local infiltration of anesthetic included in the benefit

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Visit & Procedure Exceptions

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

These procedures may be claimed in addition to a visit on the same date, even when the diagnostic codes are the same. Exclude procedure time from your visit modifier time.

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Visit & Procedure Exceptions

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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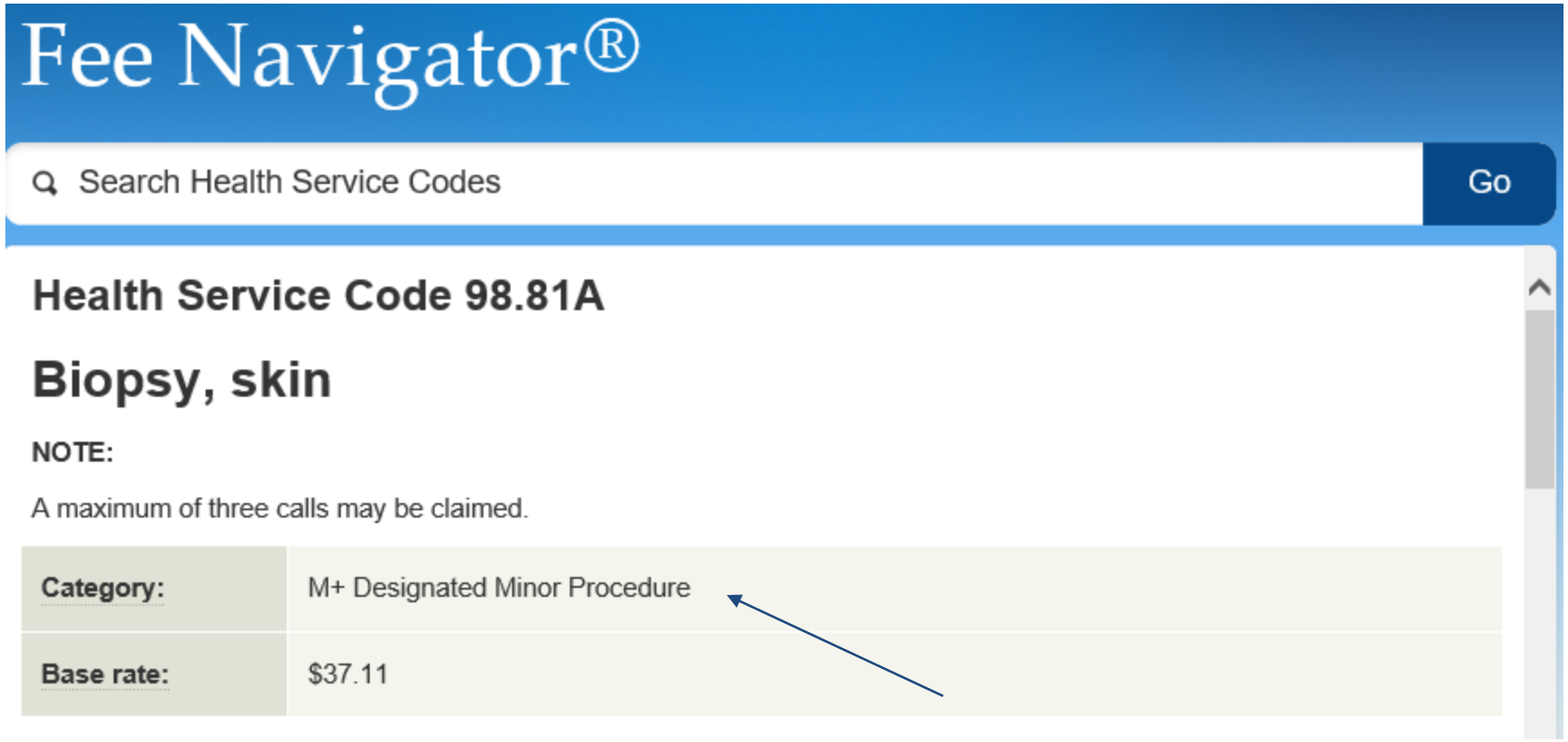
Diagnostic Surgical Procedures



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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; seborrhoeic 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

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Minor Procedures Paying < Office Visit

- In physician's community office:
  - Claim both the visit and procedure – if the procedure has a tray fee attached
  - Look for MINT or MAJT in the price list
  - The tray fee will automatically pay in your community office, but not in hospital
  - Why? It's meant to recognize some costs of doing procedure in office

- In hospital:
  - Look at total time required for the procedure and related same-day patient work
  - Bill the greater of either visit + modifier(s) OR procedure

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Laceration Repair 98.22A / B

98.22A	Up to 2.5 cm on face, 5 cm on body	$ 57.05
98.22B	2 or more calls (i.e. > 5 cm on body)	$ 60.22

- 3 Ls: Length, Location and Layers
- Any method of skin closure excluding tape / bandage
- Suture removal included
  - Same physician
  - Same practice group
- Local anesthetic included
- Minor procedure, claim with visit when visit will pay more; AH will pay tray fee

May be claimed only for repair of lacerations. Closure of a wound created through a minor surgical procedure, or removal of a penetrating foreign body, is part of the work paid for in the listed rate.

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BMI Modifier

- Pays an additional 25% for
  - BMI of 40 or greater or pediatric patient at > 97th percentile for weight on growth chart
    - Applicable to selected procedures provided in any location (including office, ER, etc.)
  - Examples
    - 13.99BA – pap smear
    - 13.99BE – pelvic exam using speculum requiring swab(s)/sample(s)
    - 98.22B Suture – laceration >2.5 cm on face; >5 cm on body

Look on the AMA Fee Navigator to determine procedures' eligibility for the modifier.
Be sure to record patient's height/weight on chart when claiming.

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Questions?

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Monitoring

- The physician is ultimately 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

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Monitoring cont'd

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

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Resources

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Resources

- **AMA Fee Navigator®**
  - www.albertadoctors.org/fee-navigator
- **AMA Billing Advice**
  - billingadvice@albertadoctors.org
- **Alberta Health Bulletins**
  - 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 & Wrap-up

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Thank you!

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