AMA Billing Seminar
CWC Primary Care Network
Understanding and Preventing Alberta Health Claim Rejections

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Session Overview

1. Understanding the AB Physician Fee Schedule
   - Philosophy
   - What is/isn’t insured; is/isn’t paid?
   - Components (price and procedure lists, rules, etc.)
2. Common Rejection/Explanatory Codes
   - Patient Registration
   - Office visits
   - Office procedures
   - Hospital/Long Term Care

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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
  - 1-800-272-9680 780 482-2626
  - E-mail:

    billingadvice@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

- 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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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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New Rule – Daily 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

Claims are sorted in fee code order for payment.

This can be a reason for partial payment.

- 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)
- Also includes home and non-regulated facility visits (e.g. assisted living, designated assisted living)
- 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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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 – don’t accept at face value

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Top 2 Explanatory Codes

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63 – Claim in progress

- Claim is being held
  - 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
  - Maximum number of special call backs exceeded (GR 5.2)
  - Maximum number of services (biopsies, warts)
  - Claim is for 51-65th V category service
- Review notes associated with HSC
  - 13.99BA (Pap) 2/year/patient/physician
    - Additional will pay with text
- Review notes associated with headings

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Patient Registration and Physician Licensure/CPSA Approvals

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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
- Opted out
- Reciprocal billing
  - Check name against photo ID
  - Copy all OOP cards
  - BC IVR # 1-800-742-6165
  - Bill patients directly
    - if they can't produce evidence of AB or other provincial health insurance (excluding Quebec)
    - If they are here temporarily from outside Canada
    - If they are refugees (Interim Federal Health Program)

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Registration problems (05)

- 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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How to deal with invalid PHNs

- Invalid registration number
  - In your office
    - Bill patient
    - Put a note in the patient's record to check validity when they come back
    - so that it doesn't happen again
  - Hospital
    - Bill patient directly, or have the patient attend a nearby registry office to register (AH Bulletin Gen 122)

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Verifying Coverage

- Reciprocal billing (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
- Invalid Alberta registration number
  - Office
    - Check numbers in advance of service
    - Bill patient if no coverage
    - Make a pay to patient claim when coverage in place
  - Hospital
    - Check NetCare
    - Bill patient if no eligibility
    - Indigent Alberta patients – connect with AHS social work

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47 – Service recipient PHN

- Claim refused as cannot change ULI
  - Delete original claim
  - Submit new claim with correct number

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20B –Armed Forces, Federal Penitentiary

- Not eligible for AHCIP coverage
- Armed Forces – processed by Medavie Blue Cross
  - Questions - Medical Officer at Base
- Federal Penitentiary – Set up vendor number to submit claims

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21 – WCB

- Service is responsibility of WCB
  - Usually happens after matching process between WCB & AH
  - Current contract with WCB allows for unbundling – all services at 100%, Visit payable in addition to procedure – claim accordingly
    - WCB will remain responsible for first visit and 25% additional payment
  - WCB and AMA are working on a proposal to have recoveries resolved between WCB and AH
    - Currently under discussion between WCB and AH

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22 – Ineligible patient- OOP

- Means Patient is responsibility of another province
- Prevention
  - Verify card is current format (see Physicians' Resource Guide)
  - Check against the patient's photo ID
  - Scan or copy health card, store in patient's file
- Contact appropriate provincial plan
  - Phone numbers available in Physician Resource Guide

When submitting claims for out of province patients, remember:

- The patient's home province address is required
- When entering the address its important to avoid any punct5uation, e.g., PO Box, not P.O. Box

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25 – Excluded service/reciprocal programs

- Payment has been refused as service is not billable under the reciprocal agreement – includes
  - Cosmetic services
  - Routine periodic health exams
  - Services for members of CAF or RCMP
  - Any team conferences
  - Reversal of sterilization
  - Telemedicine (includes virtual care services for patients insured by other provinces except NWT)
  - See Physician Resource Guide, List of excluded services in Physician Resource Guide - section 5.2 for complete list
- Bill patient directly

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25A – Medical reciprocal – incorrect claim

- Patient covered by Alberta Health
- Valid AHW number on the Statement of Assessment

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30 – 30H Person data segment

- 30 - Address - invalid, incomplete or blank
- 30A - Province - invalid, incomplete or blank
- 30AA - City - invalid, incomplete or blank
- 30AC – Postal code is invalid
- 30B – Date of birth - invalid, incomplete or blank or after date of service
- 30BA – Gender – invalid or blank

- To resolve, amend claim to include required information

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30 – 30H Person data segment

- 30E – Surname – invalid or blank
- 30EA – First name – invalid or blank
- 30EB – Middle name – invalid
- 30F – Person type – invalid or blank
  - RECP (service recipient)
- 30G – Guardian/parent PHN – invalid or blank
- 30H - Guardian/parent Health Plan number – invalid or blank

- To resolve, amend claim to include required information

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31 – Incomplete person data segment

- Person data segment
  - Required
    - OOP
    - Newborn
  - Incomplete
    - Name – surname, first name, middle (if know)
    - Birth date (YYYMMDD)
    - Gender (M or F)
    - Home province address

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31A - Person data segment conflict

- Patient information submitted is not the same as what Alberta Health has on file
- Copy of the OOP card will allow you to correct your information and resubmit the claim or advise AHW that information is correct as submitted
- Resubmit with text

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10 Ineligible Practitioner

- Claim refused as practitioner is not approved to provide the service claimed
- Needs CPSA approval
  - ECG, pulmonary function testing, diagnostic imaging etc.
- OR
- Requires specialty designation

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10AA Ineligible Practitioner

- Claim refused as practitioner is not eligible to provide the service claimed
  - Check description to see if service is a medical service or allied health service

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90D– Adjustment – recipient no longer eligible

- Adjustment to update records only

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Claim Actions and Data Fields

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35 – Action code

- Action code is invalid
  - A (add), C (change), R (reassess), D (delete)
- Action code “R” (reassess) is only allowed if text is supplied and original claim number used
- Action code “D” (delete) can only be used on pay to “BAPY” (Business arrangement payee) – pay to patient claims cannot be deleted
- Action code “C” (change) cannot be processed on a refused claim

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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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35E – Confidential indicator

- Is invalid
  - “Y” is the only valid code
- Used when you do not want the service to appear on the patient’s statement of account

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35FA – Submission of a claim number

Claim number was previously used on:

- a) refused claim
- b) claim which is being held
- c) paid service event or claim applied a zero

- NOTE: If a claim is held, do not resubmit until you have received an assessment response from Alberta Health

You can email Alberta Health with questions about held claims at the address mentioned at the beginning of this presentation.

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35FB - Unable to process updated transaction

- Occurs when resubmitting previously submitted claims
- Occurs when trying to update/change a previous claim which was
  - Deleted
  - Held
  - Not submitted

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35K – Pay to code

- Is invalid or cannot be changed
  - Trying to change a pay to patient to pay to practitioner or vice versa

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39 – Date of service

Date of service is:

- a) invalid or blank
- b) more than one year from date of birth (newborn)
- c) in conflict with explicit modifier
  - May have used a WK modifier on a weekday
  - 03.01AA modifiers for statutory and designated holidays can be problematic

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39B – Health service code

- Payment refused as HSC is
  - invalid or blank
  - not listed in the SOMB
  - Code may have been deleted from SOMB

- Ensure you're referencing the Fee Navigator or most recent version of the Schedule

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39BA – Gender restriction

- HSC does not agree with gender information on file
  - Check to see that correct ULI was submitted
  - May have to contact AHW to correct records
  - For transgender patients, add text to claim explaining

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39BB – Age restriction

- Patient does not qualify for service due to age restrictions
  - e.g. 13.59O (botox injection for chronic migraine)

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39C – Number of calls

a) Number of calls is invalid or blank
- If calls left blank the assumption is that it is one call/unit

b) Number of calls on the claim is more than allowed
- Unless the specific item has a note associated indicating maximum allowed is “X” – additional calls are allowed – text required

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39D - Location of service

- Not appropriate for HSC
- Location restrictions on some services
  - 03.03D (hospital day) – hospital, long term care facility
  - 03.05A (ICU visit) – hospital – ICU
- SOMB does not identify restrictions – look to the wording of the code
- Resubmit with correct location or HSC

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39DA - Facility number

- Is invalid or blank
- Facility listing
  - January 2022 is latest version
  - Updates/changes can be found at 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 supportive living

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39DB - Functional centre code

- Is invalid or blank
- Does not exist in facility submitted
- Verify functional centre against facility number listing
- Community Clinic
  - EXRM
- In patient
  - ICU1, ICU2, ICU3, ICN1, ICN2, ICN3, ICO1, ICO2, ICO3, LTC, MED, SURG, CLNC
    - 03.05N (Callback to inpatient – MED)
    - 03.03D (MED, not SURG)
    - SURG = OR
    - EMRG = Emergency Room

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Functional centre cont'd

- Out-patient
  - CLNC, D/N, EMRG, PEMG
    - 03.03KA (ER visit) – ER only
- Diagnostic & therapeutic Services – hospital
  - CLAB, DMG, ELEC, HBO, OLAB, RDON
- Mental Health regional clinic
  - EXRM
- Correctional facilities
  - provincial – have facility numbers -- use CLNC
  - Federal do not

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39EB - Diagnostic code

Diagnostic code is invalid or blank

- All claims require diagnostic code with exception of:
  - Anesthetic services (ANE, ANEST, 36.99A)
  - Surgical assist service (SA)
  - Diagnostic imaging
  - Time premium codes (03.01AA)
- If diagnostic code added for exceptions AHW will validate
- Be clear about format
  - 780,5 (invalid s/b 780.5)

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39EC – HSC/diagnostic code conflict

- All procedural codes (M, M+, Categories 1 –15)
  - restricted to specific diagnostic codes
- Visit services (V) not restricted
    - Except 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
  - EV & WK Surcharges
- 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 >8 TNTP units (2200-2400)

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Modifier types (examples)

- Implicit – Do not have to add to claim
  - Tray service – payment will be made based on location of service
  - Age – some services are paid at different rates based on age of patient (e.g., 03.03A for pts 75+)
- Explicit – must add to claim (examples)
  - Hospital admission after 1700 hours
    - HAEV, HAEVWK, HAEVNTPM, HAEVNTAM
  - Surcharges
    - EV, WK, NTAM, NTPM
  - Time premium payments
    - TEV, TST, TDES, TWK, TNTP, TNTA
  - Complexity modifiers
    - CMGP01-10, CMXV15, 20, 30, 35, etc.; CMXC30; COINPT

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45B - Encounter number is invalid

- Claim has been submitted with a non numeric value, e.g., “ or ‘ etc.

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60 – Initial visit - major

- A second major visit within 345 days of the last one (GR 4.6)
  - Resubmit with an 03.03A or applicable repeat/minor consultation (03.07A, 03.07B) if patient referred
  - Remember complex modifiers if available
  - Exception:
    - 90 days for 03.04B (initial prenatal visit) after comprehensive visit
  - Restriction is per physician / per patient

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63B – Maximum number of calls

- Payment reduced as maximum reached

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64 – Supporting information

- Payment refused
  - Text information required
  - Operative report required

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67A - Previous payment

a) Claim has been previously paid
b) Claim applied at “0” on a previous Statement of Assessment

- Review previous Statements of Assessment for previously paid claim
  - If second visit on same date, use encounter 2 – resubmit with same claim # action code C
- Ask AHC for assistance with Statement of Assessment date

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67AB - Previous payment

- Claim has been paid under a different HSC or different claim for same patient on same date
  - Review services claimed for the patient on that date

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72 AHC & WCB claim for same visit

- AHW & WCB share files on monthly basis
  - If same date, same physician, same patient – AHW claim will be recovered unless it is 03.01J
  - Make sure charting reflects if both services done at different encounters
  - Be very clear with diagnostic coding; generalized codes will result in recovery.
  - For treatment of different illnesses/injuries on same date as WCB visit, code very specifically

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80G - Outdated claim

- Claims must be received by AH within 90 days from date of service of date of discharge in case of hospital patient. (GR 2.7.4)
- Resubmissions - 90 days from last contact with Health Care
  - If outside 180 days from DOS. Use a new claim number and add text
- Exceptions may be made on a one time only basis
  - Rare – fire, theft, flood

- NOTE: Claims are received by AH Tuesday, Wednesday, Thursday; those are the days that you should count to re 90-day submission timeframe
  - If Monday is day 90, AH will refuse a claim received Tuesday

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Procedures,
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50A – Procedures included in major procedure benefit

- Payment for some procedures are included in the major benefit
  - E.g., application of cast is included in the fracture benefit (Rule 6.11.11)
- Check specific items or general rules

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50AA – Diagnostic proc related to surgery

- Payment was refused as diagnostic procedure is included in the surgical procedure under same anesthetic
- GR 6.9.8

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51G – Surgical assist

- Payment was refused

  a) Surgical assist is not payable for the procedure performed

  - Check GR 13 for list of procedures not eligible
  - Exceptions may be made if text is submitted outlining circumstances

  b) Surgical procedure was not claimed for this date of service

  - c) Documentation was not submitted to support a claim involving unusual circumstances

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52B – Same physician – two functions

- Only one claim may be paid when both surgical and anesthetic services are performed by the same physician (GR 6.14)
- E.g., fracture reduction with conscious sedation by same physician; claim the greater

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56 - Procedure-visit (GR 6)

a) Visit & minor (M) - greater only if diagnosis are related

Exceptions if note on procedure – e.g., 13.99BA has

b) Consultation & minor (M) - greater only on same DOS

Exceptions if note attached

c) Procedure & hospital visit – greater only on same DOS

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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

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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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56A – Multiple minor procedures

- Payment is reduced to 75%
  - Greater procedure at 100%
  - Subsequent at 75%

- Does not apply to procedures with calls – they often have own rules about payment

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61H – Inclusive- benefit-pre/post-op care

Pre & post care include in surgical benefit – check price list for category codes

- Category codes:
  - M - day of procedure only
  - 1 – 0 days pre & 14 days post
  - 3 – 7 days pre & 7 days post
  - 4 – 7 days pre & 14 days post
  - 6 - 14 days pre & 14 days post
  - 14 – 30 days pre & 14 days post
  - 15 – 0 days pre & 7 days post
- Refer to price list or AMA Fee Navigator for appropriate category
- Pre does not apply to consultation except for “M”

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Delivery Benefits

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54 - Included services

- Payment refused as the service(s) is included in the delivery
  - The delivery fee includes (GR 8.1.4):
    - Surgical induction
    - Episiotomy & repair
    - Repair of non extensive lacerations (1st or 2nd)
    - Ordinary immediate care of newborn
    - Post partum hospital visit by same or different physician

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54A – Post-natal care

- Only one routine post-natal visit, per physician
  - Remember 03.03C is eligible for GMGP01 – 10 for family medicine or CMXV20/35 modifier for other specialties
  - Claimable once per physician per pregnancy

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54B - Pre-natal care

a) Only one 03.04B may be claimed per pregnancy

- In the event that the patient loses a pregnancy a second one can be claimed if text added
- Remember 03.04B is eligible for CMXC30

b) 03.04B may not be claimed within 90 days of a major visit item (03.04A or 03.08A)

c) 03.03B may only be claimed for prenatal visits

- Remember 03.03B is eligible for CMGP01 - 10 or CMXV20/35 based on specialty

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Assisted Living, Long Term Care and Hospital Care

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60C – Hospital admission

- 03.04C is not payable when patient seen by same practitioner on SDOS for same or related diagnosis (GR 4.7)
  - Exceptions:
    - New condition at separate encounter
    - Condition deteriorated requiring admission – text required
- 03.04C is eligible for CMXC30

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60EB – Services unscheduled

- Maximum benefit for unscheduled services was reached (GR 15.11)
  - Max 5 - 03.03KA, 03.05N or combination/ physician (W/D 0700 – 1700)
  - Max 5 – 03.03LA, 03.05P or combination/ physician (W/D 1700 – 2200)
  - Max 15 – 03.03LA, 03.05R or combination/ physician (W/E or Stat 0700 – 2200)
  - Max 2 – 03.03MC, 03.05QA or combination/ physician (2200 – 2400)
  - Max 7 – 03.03MD, 03.05QB or combination/ physician (2400 – 0700)

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61CB – Aux hosp / nursing home visit

- A visit for prior DOS during same week was paid
  - 03.03E Periodic chronic care visit
    - 1/week if no other visit precedes same calendar week (Sun – Sat)
    - 03.03KA, LA, MC & MD + 03.03EA may be claimed subsequent to 03.03E

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61E – Concurrent care

- Payment refused as services for concurrent care require supporting information
  - GR 4.8
  - “If the services of more than one physician are required because of the complexity of the clinical needs of a patient, each physician may claim a benefit for concurrent care. Satisfactory supporting information must accompany the claim”

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63AA - Unscheduled services & designated holidays

- Payment reduced or refused in accordance with GR 1.2 and 15
  - Date of service not a designated holiday (GR 1.2)
  - Modifier not appropriate for date of service WK on a weekday or EV on a weekend
  - If multiple claims for the same patient on the same date of service be sure that your encounter number is correct

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90D– Adjustment – recipient no longer eligible

- Adjustment to update records only

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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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