AMA Billing Seminar
CWC Primary Care Network
April 1, 2023 Schedule Changes
Virtual Care, Minor Procedures, Q&A

Presenter: Norma Shipley
AMA Fees Consultant

April 19, 2022

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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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Session Overview

1. Understanding the AB Physician Fee Schedule
   - April 1, 2023 Update – Schedule Changes
   - Virtual Care Update
   - Some common billing issues

2. Common Rejection/Explanatory Codes
   - Patient Registration
   - Office visits
   - Office procedures

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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
  - Time limitations (0830-1600 weekdays)
- AMA – Physician Advocacy
  - 1-800-272-9680 780 482-2626
  - E-mail:
    - billingadvice@albertadoctors.org
      norma.shipley@albertadoctors.org
      darcy.shade@albertadoctors.org
      arisa.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

- 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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Daily Cap – Rescinded December 1, 2022

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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Understanding the Schedule

- The Schedule pays for physicians' direct, in person, services to patients, except for:
  - Technical, delegated services (MED 97)
  - Physician to physician, physician to other health provider communications (as described), and team or family conferences
  - Specified phone/other contact with patients, including virtual codes
- Determine the correct health service code – the EMR/billing software description is only part of the story – read:
  - Full description
  - Modifiers
  - Rules

Delegated services that may be claimed:

- 13.42A (allergy injections/sublingual drops given by qualified health professional employed by physician
- 13.59A (flu, pneumococcal vaccinations in physician office by qualified professional
- COVID vaccination (13.59V)
- Services provided by medical learner directly supervised by physician (in room, eyes-on)

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Not all services can be claimed or have a specific code

- Not every patient-related activity has a specific fee code and may be claimed; some are bundled into other services; others may be part of a service claimed on an earlier date, and no additional claim or time may be added
- For example, the following may not be claimed:
  - Hand-over of patient panel – without a patient visit, there is nothing to which to attach a patient claim. 03.01LG/H/I/J/K/L series is not appropriate as this is a transfer of care.
  - Hallway consultations in primary care – the physician seeing the patient may add required time to their visit, but the other may not claim unless they see the patient separately.
  - If the consulted physician does a procedure, they may claim for the procedure; a visit may or may not be claimable, depending on the procedure
- The following may be included in visit modifier time, if they occur on the same date as the patient is seen:
  - Hallway consultations with another physician in the practice
  - Impromptu meetings with members of your care team
- Remember that some codes have specific wording that requires a certain time commitment or that the service be scheduled in advance
- Some codes have specialty restrictions; that means that the individual specialty listed has paid for the anticipated cost of using that code – contact your section to ask for consideration in future allocations.

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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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Checking patient PHNs

- How to prevent refusals for invalid registration numbers
  - In your office
    - Check numbers in advance of patient visits – use NetCare Patient Tab
      - Click the *More* button found on the patient tab, check for coverage effective and end date fields
      - Simply having a number is not confirmation of coverage!
    - No coverage? Effective date in future, or expiry in past?
      - Bill patient
      - They can resolve coverage at their local registry
      - Check coverage when they return

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Verifying Coverage

- Reciprocal billing (Out of Province Patients except Quebec)
  - 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
- Quebec patients
  - Bill directly at AB rates
  - Provide an invoice showing charges

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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…

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Virtual Care

- **Time/other requirements**
  - Physician:Patient contact time PLUS same-day patient care management time may be included
  - 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

- Premiums and modifiers
  - Limited (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 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 physician:patient contact PLUS same-day patient care management time by phone, videoconference, or email
  - Email contact with patients **must** be patient initiated; if the physician initiates contact (i.e., the patient does not begin that email string, consider using 03.01S)
  - Includes prescription renewal or new prescription (no add'l 03.01NM unless pharmacy initiates contact)
- **03.03CV (virtual 03.03A)**
  - 10 + minutes direct physician:patient 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: 03.05JR may be used to follow up by telephone 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.

If you are initiating secure email contact with patients, consider 03.01S rather than 03.01AD (may be claimed up to 14/week/physician and not with 03.05JR for same patient, same week)

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Virtual Mental Health Visits

- **Scheduled telephone/secure videoconference for treatment of psychiatric illness:**
  - **08.19CW (unchanged April 1, 2023)** – Family Med and Pediatrics (per full 15 minutes of direct physician:patient contact)
  - 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 April 1, 2023)**
  - Detailed record, including start/stop times
  - Not claimable with other virtual/in-person visits same day
  - Patient must have established history 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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Questions?

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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)** – 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).

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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 direct patient care and same-day management of patient care
- Second & subsequent units only billable when **full** 10 minutes has elapsed
- Exclude time claimed under another code (e.g., 13.99BA – pap smear; 03.01LG – physician to physician phone consultation – referring physician)
- Example:
  - 10 minutes patient direct contact + 6 minute conversation with diabetic educator + 10 minutes writing referral letter to ortho = 03.03A (office visit) plus CMGP02 modifier
  - 10 minutes direct patient contact + 8 minute conversation with physician colleague+ 10 minutes writing referral letter to psychiatry = 03.08A + CMGP02

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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) *must fulfil consultation requirements
03.07B	Repeat Consultation (only GP skill code) *must fulfil consultation requirements

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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:
The full unit of time must elapse in order to claim a unit of CMGP time – e.g., CMGP01is payable at the 15-minute mark, CMGP02 at the 25-minute mark, etc.

Remember to exclude time required for procedures or other services claimed separately and non-physician time and

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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, excluding time related to other claimed services/uninsured services
- **03.04B (Comprehensive Prenatal Visit)**
  - Not claimable within 90 days of comprehensive visit
    - Once per pregnancy
    - Includes full history, examination, initiation of prenatal record
    - CMXC30 eligible

The 345 day exclusion period for claiming another comprehensive visit is specific to the physician and patient combination; another's claim for 03.04A does not impact.

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Comprehensive Visits

Be sure to document the evaluation of all body systems when claiming a comprehensive patient visit – EMR templates can help

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.

Comprehensive visits must, as of March 30, 2020, include a care plan as part of the discussion with the patient, and this must be documented in the patient record. We suggest a specific set of actions that will be evaluated or followed up at a given time.

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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 defines care plan as
  - Specific to patient
  - Documented findings and plan for patient with actions/timelines for both
  - 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 • Include time related to same-day patient care management • Exclude time for services that will be claimed under other health service codes	$31.43

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Complex 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) (not part of 345 day group)
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

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Activities that Contribute to CMX

- Complexity is solely determined by time related to care of the individual patient on the date they are seen (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 who has additional training/experience in treating the patient's problem
- 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**

GP-GP Consultations not payable when both work in same facility – considered transfer of care

If care is transferred from Physician A to B in ER – consider 03.05FF, FG, FH, depending on time of day/day of week.

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Procedures,
Procedures and Visits

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Procedure inclusions

- Payment for some associated services is included in the major benefit, e.g.,
  - Application of cast is included in the fracture benefit (Rule 6.11.11)
  - Local anesthetic infiltration is included in the amount paid for procedures
  - Removal of sutures is included in procedure paid unless placed in ER or as inpatient and removed by, e.g., family physician
- Check specific items or general rules
- Be sure you understand the requirements for a code before claiming
- In doubt? Check it out – billingadvice@albertadoctors.org

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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

Procedures on this page may always be claimed in addition to a visit on the same date – exclude procedure time (consent, set up, procedure, post-procedure care) from time of the visit.

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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)

Procedures on this page may always be claimed in addition to a visit on the same date – exclude procedure time (consent, set up, procedure, post-procedure care) from time of the visit.

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Payment for multiple procedures

- Payment is adjusted for the lower value procedure(s) at the same encounter
  - Greater procedure at 100%
  - Second and subsequent at 75% (unless otherwise indicated)
- Does not apply to procedures with calls – they often have own rules about payment
  - See the individual item for more information
- Payment for procedures is for completion, no time modifiers are available. Some individual procedures do have time based payment – e.g., 98.12H (excision soft tissue tumor – full 30 minutes of operating time, first call)
  - If you are unable to complete the procedure, claim the associated visit and use time modifiers to account for additional time.

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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 and immuno-suppressed patients
  - molluscum contagiosum

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Treatment of Warts

NOTE: The following may all be claimed in addition to a visit on the same date – exclude procedure time from visit time when considering modifiers		
98.12J	Removal or excision (warts, keratoses) • Maximum of 4 calls claimable	$19.09
98.12L	Non-surgical treatment (cryotherapy, chemotherapy) warts or keratoses • Only one claimable whether one or many treated (plural wording)	$13.74
98.12R	Removal of first plantar wart • 2nd at same encounter • 3rd at same encounter Amounts are calculated to reach pre-determined maximum payment	$35.26 $14.10 $ 1.89

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Cutaneous Vascular Tumors

98.12G	Laser removal of cutaneous vascular tumors • Minor procedure, not claimable on same day as a visit • May be claimed when laser treatment of cutaneous tumors is provided using appropriate and recognized equipment	$66.97

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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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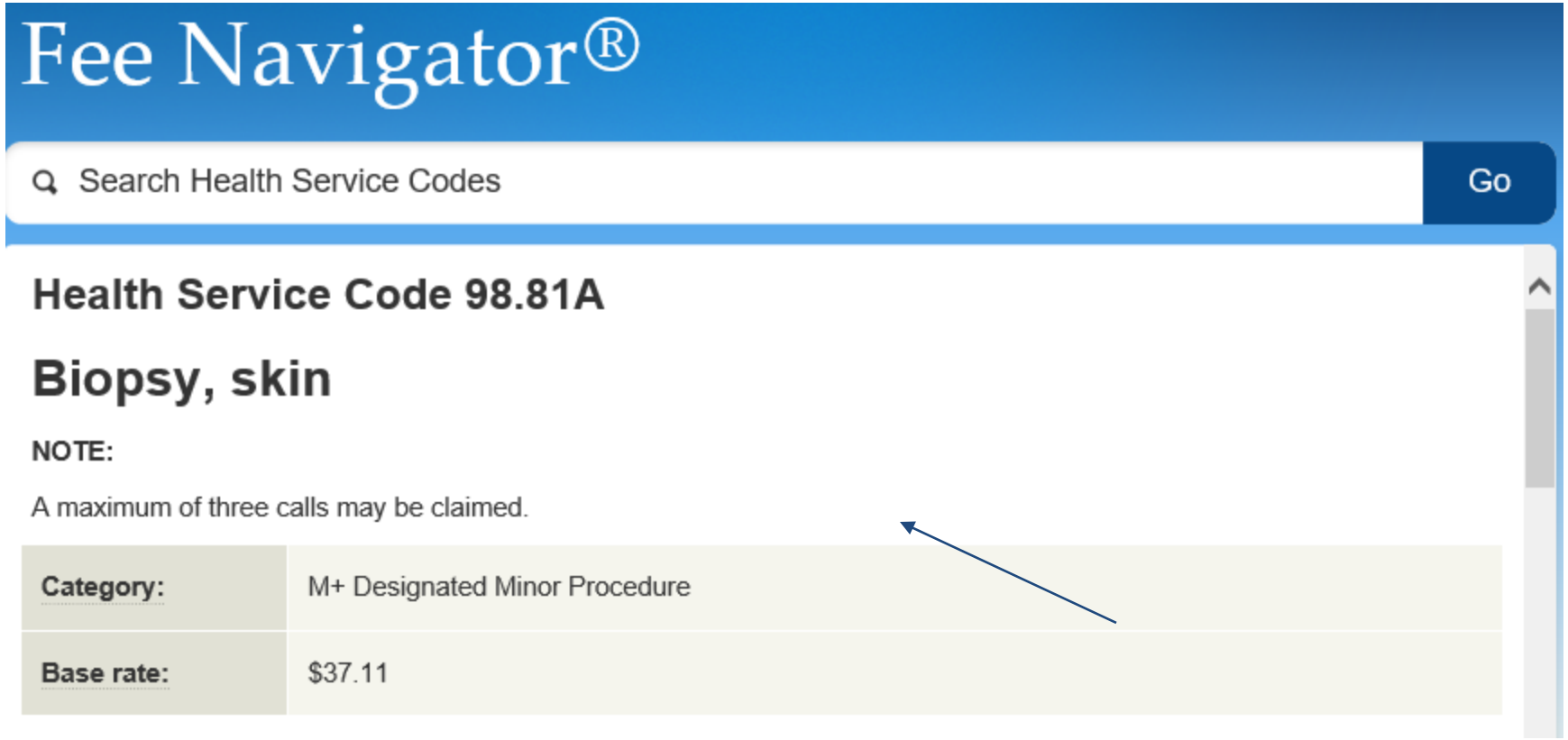
Diagnostic Surgical Procedures



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Biopsies and Excisions

98.12A	Excisional biopsy, skin (maximum 3) (M+) • Each additional biopsy site pays 75% of initial	$42.77 $32.78
98.12B	Excisional biopsy, face (maximum 3) (M+) • Each additional pays 75% of initial	$54.85 $41.14
98.12C	Removal sebaceous cyst (maximum 3) (M, but claimable with visit) • Each additional pays 75% of initial • Must be medically required	$38.30 $28.73
98.81A	Biopsy skin (maximum 3) (shave biopsy included) (M+) • Each additional pays 75% of initial	$37.52 $28.14
98.81B	Punch Biopsy (M+) • Second at same encounter paid 75% of initial • This is different from MOHs surgery which requires special equipment/education/training	$19.44 $14.58

Most biopsies are M+ procedures; billable with a visit at same encounter in community office; exclude time from visit modifier time.

When the maximum stated is 3, that is the total that is payable for that code on that date, regardless of the number of biopsies done.
This does not mean that additional biopsies are not insured.

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Biopsies and Excisions

98.12A	Excisional biopsy, skin (maximum 3) (M+) • Each additional biopsy site pays 75% of initial	$42.30 $31.73
98.12B	Excisional biopsy, face (maximum 3) (M+) • Each additional pays 75% of initial	$54.25 $40.69
98.12C	Removal sebaceous cyst (maximum 3) (M, but claimable with visit) • Each additional pays 75% of initial • Must be medically required	$38.17 $28.63
98.81A	Biopsy skin (maximum 3) (shave biopsy included) (M+) • Each additional pays 75% of initial	$37.11 $27.83
98.81B	Punch Biopsy (M+) • Second at same encounter paid 75% of initial • This is different from MOHs surgery which requires special equipment/education/training	$21.59 $16.19

Most biopsies are M+ procedures; billable with a visit at same encounter in community office; exclude time from visit modifier time.

When the maximum stated is 3, that is the total that is payable for that code on that date, regardless of the number of biopsies done.
This does not mean that additional biopsies are not insured.

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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-op inclusive period does not apply to consultation except for “M”

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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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