Welcome to the AMA Billing Event Calgary West Central PCN

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Attendees' microphones will be muted and cameras turned off during the presentation

Please click on the Q&A icon to ask questions

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- **Audience instructions:**
- All attendees' microphones are muted, and your webcams turned off; screens cannot be shared.
- Please participate in the webinar by asking questions through the Q&A panel and/or by liking questions asked by other attendees.
- In the Q&A panel, attendees can sort questions by "most recent" or "most liked".
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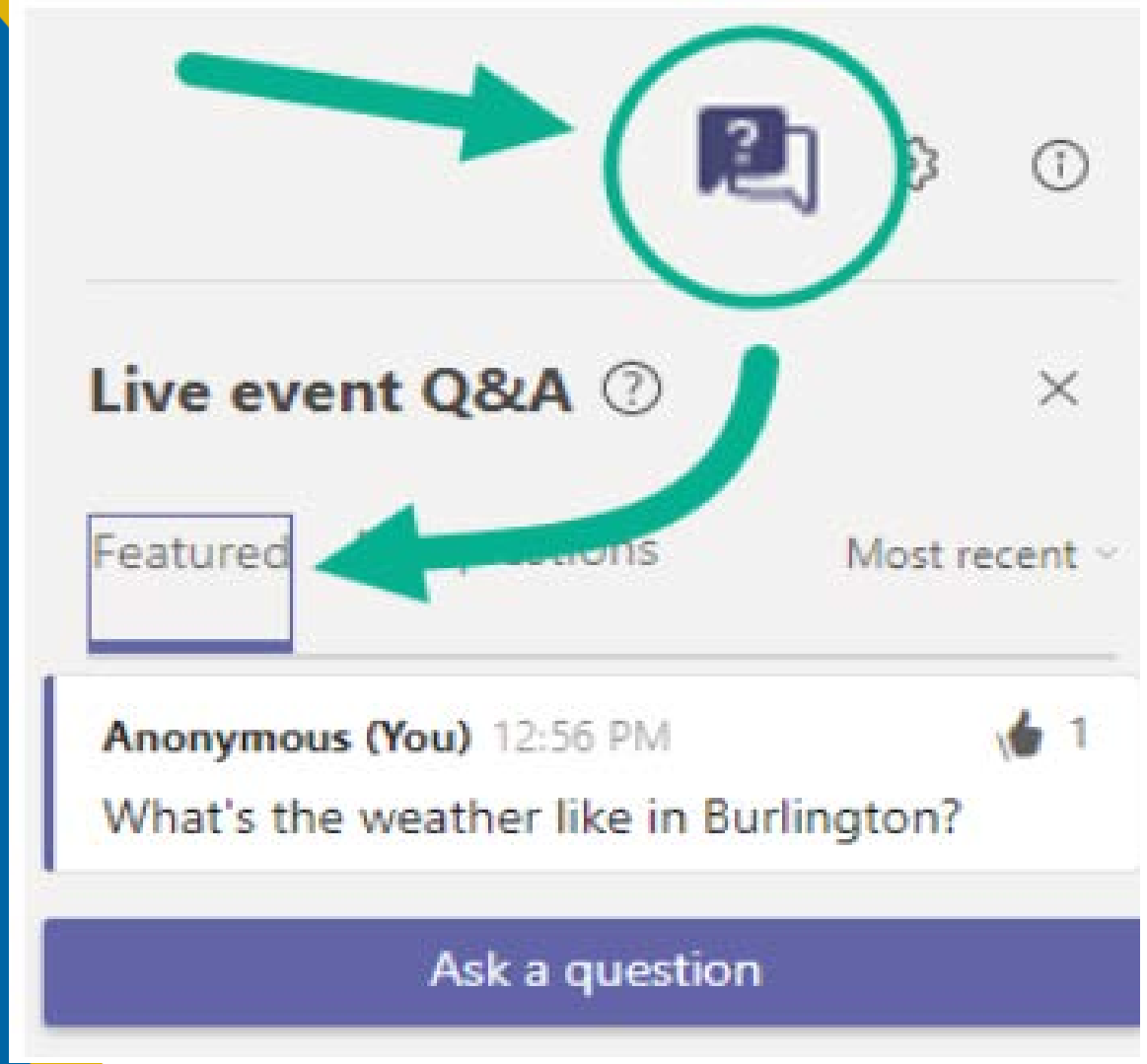

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Session Overview

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. Update on virtual codes and March 31 changes
3. Areas of practice
4. Staying up-to-date
   - When/where are changes published?
   - Virtual Codes, March 31 changes
5. Monitoring
   - Optimizing your billings
   - Alberta Health review

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Schedule of Medical Benefits and Billing Basics

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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 – you decide what fee code, and how many, to bill!

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Virtual Care Billing Codes

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Virtual Care

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

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Virtual Care

- **Time/other requirements**
  - Physician:Patient contact time only; no other time may be included
  - 03.01AD <10 minutes
  - All other codes – at least 10 minutes, or other noted time requirement
  - Start/stop times must be part of detailed patient record
  - No other codes (except 03.01NM, where appropriate) may be claimed same date

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Virtual Care

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

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Virtual Visits

- **03.01AD**
  - <10 minutes direct contact by phone, videoconference, or email
  - Includes prescription renewal or new prescription
- **03.03CV (virtual 03.03A)**
  - 10 + minutes direct contact, phone or video
  - Limited assessment of problem, advice to patient, record (including start/stop time)

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Mental Health

- **Scheduled telephone/secure videoconference for treatment of psychiatric illness:**
  - **08.19CW** – Family Med and Pediatrics (/full 15 minutes)
  - Includes medical psychotherapy, medication prescription, reassessment, patient education and/or counseling, including group therapy
  - NEW – may be claimed for palliative care and chronic pain care within multi-disciplinary program
  - **Direct physician:patient time only**
  - 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 haven't changed and follow established rules for in-person visits
- Only physician:patient direct interactions claimable
- Patient-initiated visit can include:
  - A patient initiated appointment regarding a new problem
  - Consultations and clinically-necessary follow-up of an ongoing condition or previously initiated treatment plan
  - Direct patient contact resulting from panel management to ensure chronic and high-needs patients receive appropriate care
  - Physician:patient contact following referral by AHS screening program (including COVID-19)

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Virtual Care Examples

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

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Virtual Care Examples

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

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Effective Dates and Billing

- All codes are now active in the claims system and may be claimed
- 03.01AD may be claimed for services March 12 forward
- The other virtual codes may be claimed for services provided March 17 forward

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Questions?

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Schedule of Medical Benefits Changes

March 31, 2020

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Schedule Changes

- Alberta Health imposed the following changes **March 31, 2020, and updated some April 23**
- AMA **has not been** involved in initial development, or determination of exceptions published April 20:
  - AMA does not support the overall changes
  - April 23 exceptions are a first step, but overall review and collaboration is required to ensure fair and appropriate
- Any errors, inconsistencies in these changes, or application of rules are Alberta Health's responsibility

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Submission Deadlines (GR 2.7.4)

- Starting 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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Submission Deadlines (GR 2.7.4)

- **What does this mean?**
  - For services provided up to and including March 30, you may submit claims up to 180 days with text
  - March 31 forward, only those within 90 days will be automatically assessed
  - Claims outside 90 days, submitted on or after March 31 will be manually assessed, and require text

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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
- We have asked AH for definition of care plan
  - Must be specific to patient
  - Documented findings and plan for patient, including follow-up
  - Recorded in patient’s record

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New Rule – Daily Cap

Affected Communities:		
Edmonton	Sherwood Park	St. Albert
Devon	Stony Plain	Leduc
Ft. McMurray	Grande Prairie	Airdrie
Red Deer	Calgary	Medicine Hat
Lethbridge		

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

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New Rule – Daily Cap

- Applies to all V category services, excluding 03.05LB, 08.44A, 08.44B, 08.44C, 08.44D, and 13.82A
- Includes phone calls to patients, team and family conferences, communication by phone/telehealth with other physicians, health professionals, community agencies
- Also includes home and non-regulated facility visits (e.g. assisted living, designated assisted living) – NEW Information
- Does not apply to rural communities, hospitals, and emergency room services

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Deleted Codes

- **03.04J (Comprehensive care plan)**
  - **Delisted**, becomes part of 03.04A requirements
  - Rule change for comprehensive visit adds care plan to required activities
  - Must be documented care plan in patient's chart, e.g. goals, monitoring, dates
- **03.05H (Driver's Medical, 74.5 yrs and older)**
  - **Uninsured**
  - Physicians must not claim either the visit or form completion to Alberta Health
  - The AMA Guide to Billing Uninsured Services can help with setting appropriate rates

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New Codes – Out-of-Office Visits

- **New visit and consultation codes – the Z codes**
- **Specific visits and consultations**
- **Provided outside physician' offices, in publicly funded facilities**
- **NEW – April 23 – although physicians must use Z codes for services in public facilities**
  - Paid at same rate as base code in rural sites – ongoing (e.g. 03.03AZ will pay same as 03.03A)
  - Other sites, rates on hold until October 1
- **Exception: Physician's office or clinic in public facility where:**
  - There is a separate facility number; and
  - Physician pays an overhead amount to AHS

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New Codes – Out-of-Office Visits

- **What public facilities are included?**
  - Active Treatment Center/Hospital
  - Ambulatory Care Centre
  - Auxiliary Hospital
  - Health Canada Nursing Station
  - Community Ambulatory Care Centre
  - Community Mental Health Clinic
  - Nursing Home
  - Regional Contracted Practitioner Office
  - Subacute Auxiliary Hospital

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Out-of-Office Visits

New Code	Description
03.03AZ	Limited visit, out of office
03.03BZ	Prenatal visit, out of office
03.03FZ	Repeat office visit or scheduled outpatient visit in a regional facility, referred cases only, out of office
03.04AZ	Comprehensive Visit, out of office
03.05IZ	Palliative care visit, out of office
03.07AZ	Minor consultation, out of office
03.08AZ	Comprehensive consultation, out of office
03.08BZ	Obstetrical Consultation, out of office

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Out-of-Office Visits

New Code	Description
03.08IZ	Prolonged consultation (internal medicine and subspecialties), per 15 minutes or major portion, out of office
03.08JZ	Prolonged consultation (pediatrics and subspecialties), per 15 minutes or major portion, out of office
08.19AZ	Major psychiatric consultation, out of office
08.19GZ	Direct contact, psychiatric treatment, out of office (Includes both 08.19G and 08.19GA)
08.45Z	Family therapy, out of office

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Out-of-Office Visits
Things to think about…

- If a physician has a physician-funded office located in an AHS facility, any service provided outside the office facility would still be subject to the Z codes
- This means services in the following areas would be continue to be claimed using the hospital facility number and functional centre:
  - Emergency room
  - Inpatient ward
  - ICU
  - Outpatient clinic other than the office facility
- If the code used before March 31 does not have a Z code equivalent, continue using the pre-March 31 code

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DI Referrals

- Imaging services referred by a chiropractor, physiotherapist or audiologist
  - **Uninsured**
- Chiropractors, physiotherapists and audiologists continue to be able to refer these services to DI
- Patients now responsible for cost of these services
- Family Medicine may see requests for these referrals from patients

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Questions?

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Billing Specifics

Overarching Rules, etc.

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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
- AMA – Physician Advocacy
  - 1-800-272-9680 780 482-2626
  - E-mail:
    billingadvice@albertadoctors.org
    norma.shipley@albertadoctors.org
    darcy.shade@albertadoctors.org
    marisa.bonuccelli@albertadoctors.org

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Verifying Coverage

- Netcare or IVR (1-888-422-6257)
  - All new patients, those not seen recently, life change (young adult, change in marital status)
  - Check date of coverage
- Opted out
  - A few Albertans have formally opted out of health care insurance
  - Bill directly – not limited to Schedule rates
- **Be aware: Good Faith Claims discontinued**

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Verifying Coverage

- Reciprocal billing
  - 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 supports

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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, calendar or app in your electronic device
  - Exclude any time for breaks
  - Include any time you spent after office/clinic hours on work related to patients seen that day
  - Retain for 6 years

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Delegated Services (GR 2.7.5)

- The Schedule pays for direct physician services to patients
- There are a few exceptions (AHC - MED 97)
  - Technical services (in office)
  - Delegated services (13.42A – allergy desensitization; 13.59A – flu, pneumovac) (nurse working in physician office)
  - Physician in training – physician must be directly supervising

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Immunizations

- **Covered by AH:**
  - Flu – physician or nurse
  - Pneumococcal – physician or nurse
  - Tetanus – for wound management – physician only
  - Childhood immunizations – physician only
    - Only for preexisting 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 specific 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
  - Virtual care
    - One virtual care service claimable per day
    - Not claimable same date as in-person service

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Billing Specifics

Visits and Consultations

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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)** – examination and history focused on the presenting problem (eligible for CMGP modifier).
  - **Prenatal Visit (03.03B)** – eligible for CMGP modifier
  - **Brief assessment (03.02A)** – minimal history, little or no physical examination (no modifiers).

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Comprehensive Visits

- **03.04A (Comprehensive Office Visit)**
  - 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)
  - Must include a care plan (NEW)
  - CMXC30 applicable
- **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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Minor and Repeat Consultations

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

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Complex Care – Family Practice

CMGP	Complex patient consultation/visit – first FULL15 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

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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	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	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	Minor consultation (only GP skill code)
03.07B	Repeat Consultation (only GP skill code)

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Using CMGP

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

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Complex Care Comprehensive Visits

CMXC30 (All)	Complex patient consultation / visit requiring that physician spend 30 minutes or more on management of patient care (only one claimable)	$31.43

- Claimable with 03.04A, 03.04B, 03.04C, 03.04D, 03.04E, 03.04M, 03.08A

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Complex Care cont'd

Visits and Consultations eligible for CMXC30 modifier	
03.04A	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	Comprehensive Consultation

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Activities that Contribute to CMX

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

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Visits vs. Consultations

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

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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 not active treatment facility staff

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

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Rules for Phone Advice

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

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Advice to Pharmacist

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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E-Consultations cont'd

03.01O	Physician or nurse practitioner to physician secure e-consultation – consultant	$68.65

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

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Billing Specifics

Family Conferences/Other Indirect Services to/Communication with Patients

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Family Conference via Telephone

03.05JP	Family conference via telephone relating to acute care facility in-patient, registered ER or out-patient, LTC, hospice patient UCC or AAAC patient	$41.20

- Intended for patients who are unable to communicate or require periodic family conferences
- Location or mobility factors preclude meeting in person
- Timely communication with family is essential to patient care or organ/tissue transfer/collection
- Communication about patient condition or to obtain collateral information relative to patient management and care activities
- **Not claimable** for relaying lab or DI results or arranging follow up care
- Documentation of communication to be maintained in patient record

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Family Conference via Telephone cont'd

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

- 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 /15 min or major portion thereof	$51.98
• With patient's family members – scheduled in advance; not for accompanied visit		
• Document name and family relationship of attendees		
• Max 3 hrs/year/patient/physician		
03.05JC	Family conference relating to acute care facility inpatient or registered emergency or outpatient, auxiliary hospital or nursing home patient, AACC or UCC patient (per 15 minutes or major portion thereof)	$42.47
• Max 3 hrs/year/patient/physician		
• Intended for patients whose condition warrants periodic family conferences		
• Not intended for bedside discussions with patient family		

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Team Conferences

03.05JA	Formal, scheduled, multiple health discipline conference /15 min or major portion thereof	$42.47
• With para medical personnel re: health care where social & other issues involved • Not intended for review of physician panel • Must be booked to discuss specific individual patient, and • Discussion regarding individual patient must be 8 minutes or more to claim.		
• More than one physician – text required		
• Max 3 hrs/year/patient/physician (April 1 – March 31)		
• Not billable at same encounter as visit		

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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) – New November
- May not be used for INR management
- Not claimable for same patient in the same calendar week as 03.01S or 03.01T

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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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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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Billing Specifics

Other Visits and Patient Care

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Psychotherapy (08.19G)

08.19G	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
- Direct patient contact time only

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Palliative Care

Definition: Terminal Disease, Multidisciplinary Team (GR 4.2.4)		
03.05I	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 residential addiction 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
- Not billable for patients undergoing cataract surgery under local

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Capacity Determination

03.04N	Comprehensive evaluation including completion of forms to determine capacity as defined by the *Personal Directives Act (PDA) (RSA 2007 s9(2)(a)*	$193.34
NOTE: 1. Benefit includes witnessing the agents' or service providers' assessment. 2. May be claimed to determine lack of capacity or to determine that capacity has been regained.		

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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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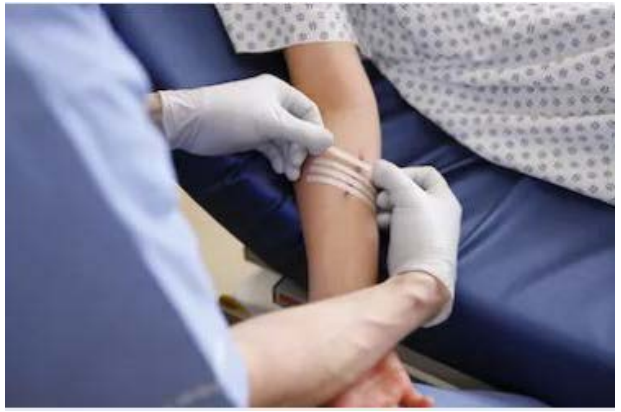
Procedures

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



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Visits with Procedures

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

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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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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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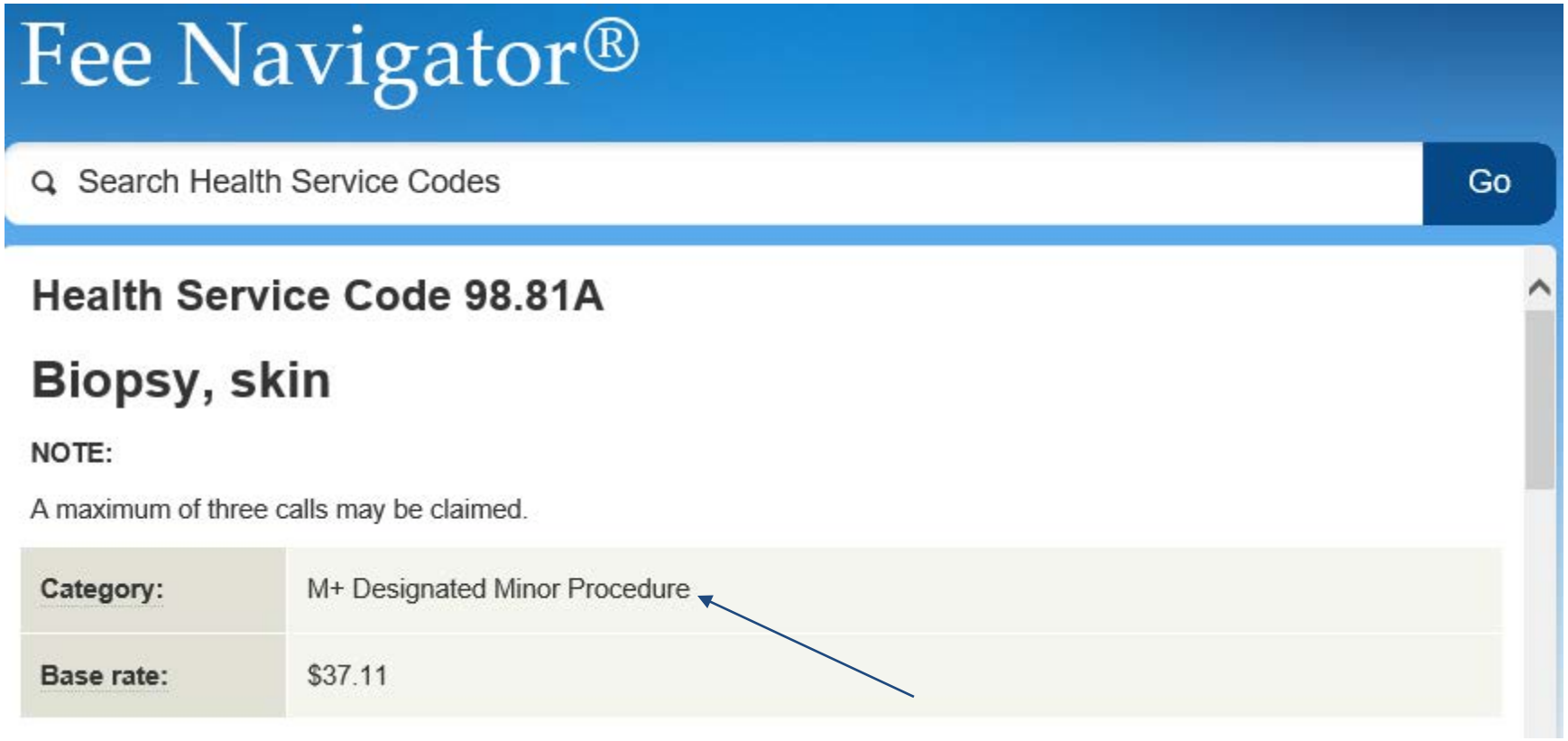
Diagnostic Surgical Procedures



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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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BMI Modifier

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

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Emergency Services

13.99J	Medical emergency detention time, per 15 minutes or major portion thereof	$60.22

- Personally & continuously attend and treat an illness or injury of an emergency nature
- Text required
- Time based / 15 minutes / cumulative
- Not for standby or spending a long time with a patient
- Maximum of 8 per day, per physician in office
- Maximum of 16 per day, per physician other than office

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WCB Services

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Overview

- Legislative authority
- Payment rules
- Monitoring

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Legislative Authority

- Section 34 – Report by Physician

  "A physician who attends an injured worker shall

  a) forward a report to the Board

     i. within 2 days after the date of the physician's first attendance on the worker if the physician considers that the injury to the worker will or is likely to disable the worker for more than the day of the accident or that it may cause complications that may contribute to disablement in the future, and

     ii. at any time when requested by the Board to do so,

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Legislative Authority cont'd

b) advise the Board when, in the physician's opinion, the worker will be or was able to return to work, either in the physician's report referred to in clause (a)(i) or in a separate report forwarded to the Board not later than 3 days after the worker was, in the physician's opinion, so able, and

c) without charge to the worker, give all reasonable and necessary information, advice and assistance to the worker and the worker's dependents in making a claim for compensation and in furnishing any certificates and proofs that are required in connection with the claim."

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Legislative Authority cont'd

- Section 86 – No charge for medical aid

  "No part of the cost of any medical aid provided to or in respect of a worker under this Part is payable by the worker."

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Payment Rules

- **AHW SOMB Rules:**
  - Except for unbundling – defined as:
    - Visit payable with procedure
    - All services paid at 100% - same encounter
      - Exception – where 2nd procedure intrinsically linked to 1st
      - E.g., local infiltration anesthetic with suturing
  - Inclusive care periods do not apply
  - Intravenous sedation with procedures - only if performed by a different physician
  - Cast application billed in addition to fracture
  - Subsequent cast applications within 14 day post operative period – payable

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Payment Rules cont'd

- First report defined as the first occasion physician sees patient
- Tray service payment is not automatic
  - Include on invoice (MAJT, MINT)
- BCP payments must be billed to WCB
  - BCP01 for every service provided that is eligible
- One BCP for each visit service including complex modifiers
  - 03.03A CMGP03
  - BCP01 or 2, depending on location – calls 4

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Rejected WCB Claims

- **Why was the claim rejected?**
  - Ineligible profession?
    - Bill AHCIP
  - Determined to be unrelated to work?
    - Bill AHCIP

- **How?**
  - AHCIP will accept outdated claims related to WCB recovery

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WCB Report Definitions

- Follow up/progress report:
  - Same day – Report received at WCB on same day as completed examination up to and including 10AM the following business day
  - On time - Report received at WCB within 4 business days of completed examination up to and including 10AM the following business day
  - Late – Not meeting on time

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Report Fees

- April 1, 2018

	First Report	Progress Report
Same Day	$74.39	$45.19
On Time	$67.80	$41.19
Late	$50.85	$30.89

- New Agreement rates increase by 1.6%
- Awaiting signature after ratification

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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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