

ALBERTA HEALTH CARE INSURANCE PLAN

Schedule
Of
Oral and Maxillofacial
Surgery
Benefits

ALBERTA HEALTH CARE INSURANCE PLAN

ORAL AND MAXILLOFACIAL SURGERY

GOVERNING RULES LIST

AS OF

01 OCTOBER 2006

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1 The Schedule of Oral and Maxillofacial Surgery Benefits is hereinafter referred to as "Schedule" and applies only to those services that are insured under the Alberta Health Care Insurance Act. The following rules apply to all benefits unless otherwise stated. Rates for anesthetic services listed in the Schedule are claimable by physicians, in accordance with the General Rules set out in the Schedule of Medical Benefits, and are not claimable by Oral and Maxillofacial Surgeons or Dentists.

1. DEFINITIONS - IN THIS SCHEDULE:

- 1.1 "Agent" means any of the following individuals who are acting under the direction of the referring physician, Oral and Maxillofacial Surgeon, Dentist, or consultant, as appropriate:
- an employee of a physician, Oral and Maxillofacial Surgeon or Dentist, or
 - a hospital staff member, or
 - a supervised physician, Oral and Maxillofacial Surgeon or Dentist in training, acting under the direction of a physician, Oral and Maxillofacial Surgeon or Dentist.
- 1.2 "Benefit Year" means July 1 of one year to June 30 of the following year.
- 1.3 "Consultation - Comprehensive" means an in-depth evaluation of a patient with a WRITTEN REPORT to the referring physician, Oral and Maxillofacial Surgeon or Dentist. This service includes the recording of a complete history, performing a complete physical examination appropriate to the Oral and Maxillofacial Surgeon's or Dentist's expertise, an appropriate patient record and advice to the patient. It may include the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient and/or the referring physician, Oral and Maxillofacial Surgeon or Dentist.
- 1.4 "Consultation - Limited" means a limited assessment of a patient and a WRITTEN REPORT to the referring physician, Oral and Maxillofacial Surgeon or Dentist. A limited consultation includes a history and examination limited to and related to the presenting problem, an appropriate patient record, and advice to the patient. It may include the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient and/or the referring physician, Oral and Maxillofacial Surgeon or Dentist.
- 1.5 "Concurrent Care" means a situation where in-patient hospital services of more than one Oral and Maxillofacial Surgeon or Dentist are required because of the complexity of the clinical needs of the patient.
- 1.6 "Cosmetic Purposes" means any surgical procedure for the alteration of appearance which has not been deemed to be medically required.
- 1.7 "Dentist" means a person who is:
- 1.7.1 registered as a member of the Alberta Dental Association and College and may, as authorized by the Health Professions Act and Regulations, use any of the following titles: Dentist, Endodontist, Oral and Maxillofacial Surgeon, Orthodontist and Dental Facial Orthopedist, Pediatric Dentist, Periodontist, Prosthodontist, Oral Pathologist, Oral and Maxillofacial Radiologist, Oral Medicine Specialist or Public Health Dentist, or

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- 1.7.2 lawfully entitled to practice dental surgery in any place outside of Alberta.
- 1.8 "Eligible resident" means a person lawfully entitled to be or to remain in Canada, who makes his home and is ordinarily present in Alberta, and any other person deemed by the Alberta Health Care Insurance Act and the Alberta Health Care Insurance Regulations (Alberta Reg. 216/81) to be a resident, but does not include a tourist, transient or visitor to Alberta.
- 1.9 "Encounter" means each separate and distinct time an Oral and Maxillofacial Surgeon or Dentist provides services to a patient in a given day (defined as 0001 to 2400). To be recorded as separate encounters, multiple services provided to a patient may not be initiated by the Oral and Maxillofacial Surgeon or Dentist or may not be a continuation of a service which began earlier in the day. An example of continuation of services is the time spent with a patient to review x-ray or laboratory results ordered during an examination of the patient earlier in the day. If the patient initiates the second and subsequent encounter(s) or the Oral and Maxillofacial Surgeon or Dentist is requested to attend the patient by hospital staff, additional encounters may be claimed.
- 1.10 "Holidays" or "Statutory Holidays" means New Year's Day, Family Day, Good Friday, Victoria Day, Canada Day, Alberta Heritage Day, Labour Day, Thanksgiving Day, Remembrance Day, Christmas Day, and Boxing Day. Where a holiday falls on a Saturday or Sunday, the Minister shall designate another day as the holiday.
- 1.11 "Own family" means children, siblings, parents and spouse.
- 1.12 "Transfer of Care" means a situation where a hospital in-patient is transferred temporarily or permanently to a physician, another Oral and Maxillofacial Surgeon or Dentist for care and where the transferring physician, Oral and Maxillofacial Surgeon or Dentist will not be involved in the treatment/care provided by the receiving physician, Oral and Maxillofacial Surgeon or Dentist. "Transfer of Care" does not constitute a "Consultation".
- 1.13 "Visit - Limited" means a limited assessment of a patient. This service includes a history and examination limited to and related to the presenting problem, an appropriate patient record, and advice to the patient. It includes the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient.
- 1.14 "Telehealth service" is defined as a dentist delivered health service provided to a patient at a designated RHA telehealth site, through the use of videototechnology. The patient must be in attendance at the sending site at the time of the video capture. Telehealth services do not include teleradiology.
- 1.15 "Videotechnology" means the recording, reproducing and broadcasting of visual images.

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1.16 Oral Maxillofacial Surgeon or Oral Pathologist to Physician or Dentist
Telephone Advice - this service is defined as the provision of telephone advice to a physician or dentist, concerning treatment or management of a patient under their care.

2 APPLICATIONS:

2.1 Where the specific case contradicts a general statement within these rules, the specific shall override the general statement.

2.2 The benefits prescribed in this Schedule are limited to the lesser of:

2.2.1 the amount claimed, or

2.2.2 the rates set out in the Schedule.

2.3 Unless extenuating circumstances exist that warrant special consideration, the Minister is not responsible for payment of a claim that is received by him:

2.3.1 more than 180 days after the date on which the service(s) was provided, in the case of a claim for benefits submitted by an Oral and Maxillofacial Surgeon or Dentist in Alberta, or

2.3.2 more than 365 days after the date on which the service(s) was provided, in the case of a claim for benefits submitted by:

- a) an Oral and Maxillofacial Surgeon or Dentist outside of Alberta, or
- b) an Alberta resident.

2.4 When a claim is resubmitted for payment, it is not payable unless it is submitted within 180 days of the last transaction date for that claim.

2.5 All medically required services are considered to be insured and patients cannot be billed for these services. If a service deemed medically required by the attending dentist is not listed in the Schedule, the service may be claimed as an unlisted procedure, under health service code 99.09S. Benefits for unlisted surgical procedures will be assessed by comparing the benefit claimed to benefits listed for similar procedures in this Schedule or the Schedule of Medical Benefits and requiring similar responsibility and skill. Documentation to support the claim must be submitted, showing how the figure requested was derived and quoting the health service code(s) the surgery was equated to.

2.6 Benefits listed in the Oral and Maxillofacial Surgery section are restricted to Oral and Maxillofacial Surgeons, with exception of the following Health Service Codes:

2.6.1	03.01DC	03.03DC	03.03DD	03.03DE	03.05DA	03.05DB
	03.05DC	03.05DD	03.07DA	03.08D		

36.3 B	36.3 E	36.3 M	36.7 A	36.7 B	37.91DA
37.99B	38.19A	39.0 C	39.1 A	39.41	39.91DB
39.83C	39.99B	39.99C	51.98B		

88.03B 88.04C

which may be claimed by all Dentists,

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2.6.2 36.3 F 36.3 G
which may also be claimed by Endodontists, and

2.6.3 03.03DA 03.03DB 03.01DL 03.04DA 98.6 DA 98.6 DB
98.6 DC 98.6 DD 98.6 DE 98.6 DF 98.6 DG
which may also be claimed by Oral Pathologists.

2.6.4 37.81D
which may also be claimed by Oral Pathologists and Periodontists.

2.6.5 01.39A
Which may only be claimed by practitioners accredited by the Alberta Dental Association and College (Skill code ATMJ must be entered on the claim in place of the regular skill code)

3 CLAIMS FOR BENEFITS:

3.1 A claim submitted by an Oral and Maxillofacial Surgeon, Dentist or a patient must be in the format prescribed by the Minister.

3.2 Claims for out of province services may be submitted by:

3.2.1 an Oral and Maxillofacial Surgeon or Dentist on behalf of an eligible resident, or

3.2.2 the eligible resident.

3.3 Benefits may be claimed by an Oral and Maxillofacial Surgeon or Dentist who is present and supervising an Oral and Maxillofacial Surgeon or Dental Resident during the provision of a service.

3.4 For administrative purposes, the start of the day is considered to be 0001. A hospital visit which takes place after 0700 may be claimed in addition to a hospital admission provided between 0001 and 0700.

4 EXCEPTIONS TO ELIGIBLE SERVICES:

4.1 Services provided by an Oral and Maxillofacial Surgeon or Dentist to members of his own family are not a benefit under the Plan.

4.2 Consultations when requested by an Oral and Maxillofacial Surgeon or Dentist for a member of his own family are not a benefit under the Plan.

5 EXCLUDED SERVICES:

5.1 Some examples of uninsured services include but are not limited to:

- advice by telephone, or other telecommunication methods, except as specified under health service code 03.01DC (telehealth services) as defined under GR's 1.14 and 1.15 or health service code 03.01DL (telephone advice services) as defined under GR 1.16,
- ambulance services,
- I.V. sedation or general anaesthetic administered by a dentist,
- Consultations are not payable for routine dental treatment or care (defined as restorative, prosthetic, periodontal, implant procedures or

for routine dental extractions). Routine dental treatment or care is not a benefit, regardless of the location or type of facility where they are performed.

- any treatment or procedure performed on the teeth, except as stated in subsection 6.1,
 - drugs/agents/medication,
 - general anaesthesia or intravenous sedation, administered by an Oral and Maxillofacial Surgeon or Dentist, including general anaesthetic materials,
 - medical testimony in court,
 - mounted and unmounted casts, split cast mountings or other prosthetic devices provided in conjunction with surgery,
 - orthodontic devices and appliances,
 - pre- and post-surgical orthodontics,
 - radiographs taken by an Oral and Maxillofacial Surgeon or Dentist, including periapical, panoramic, cephalometric temporomandibular joint and sialographic or arthrographic radiographs,
 - replacement of teeth (e.g. dental implants),
 - secretarial or reporting fees,
 - services for cosmetic purposes,
 - services that are not medically required,
 - stand by time,
 - travel time of an Oral and Maxillofacial Surgeon or Dentist to see a patient.
- 5.2 Examinations or services required for the sole use of a third party (e.g. Human Resources and Employment, Children's Services, Insurance/disability carriers, Workers' Compensation Board); medical evidence required by the police or the courts; examinations/procedures required for participation in sport, etc. are not an insured service.
- 5.3 Benefits may not be claimed by an oral maxillofacial surgeon, surgical assistant or anaesthetist with respect to a procedure performed for cosmetic reasons.
- 5.4 Benefits may not be claimed by an oral maxillofacial surgeon, surgical assistant or anaesthetist with respect to a surgical procedure for the alteration of appearance performed for emotional, psychological or psychiatric reasons unless the Minister gives approval prior to the surgery being performed.
- 5.5 Intravenous sedation by a physician for dental procedures is not an insured service unless it is performed in a hospital.
- 5.6 After a diagnosis has been established, further services such as preoperative tests, consultations, surgical procedures, anaesthetics or surgical assists associated with an uninsured service are also not insured.
- 5.7 Services, including procedures which are not medically required are not insured services and claims should not be submitted.

6 INCLUDED BENEFITS:

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6.1 The following services are included in the benefit paid for a medically required procedure and cannot be billed to the patient:

- all aspects of the surgery, including intra-bony wiring, application of bone plates, and fixation and implantable surgical appliances,
- a biopsy prior to removal of a lesion,
- discussion of biopsy or culture results with the patient,
- preparation, submission and interpretation of culture and biopsy specimens,
- removal of sutures,
- removal of teeth where teeth are present in the line of fracture and management of the fracture cannot occur without the prior removal of the tooth,
- the administration of local anesthetic, including materials.

6.2 The following services may not be billed to the patient, as they are covered by the Regional Health Authorities:

- all insured, medically required pathology and cytology procedures performed in association with an insured oral surgical procedure,
- goods and services which are covered under a contract or agreement with a Regional Health Authority.

7 CATEGORY CODES:

7.1 All benefit items in this Schedule are assigned a category code, as follows:

- G - Goods
- V - Visit
- M - Minor Procedure
- M+- Designated Minor Procedure
- R - Surgical Assist
- 4 and 14 - Major Procedures

Major procedure benefit items with designated categories (4 and 14) are considered to include insured pre-and post-operative services. (See General Rule 6 - Included Benefits).

7.2 The normal pre- and post-operative periods for major procedures are detailed below:

Category	Pre-Operative	Post-Operative
4	7 days	14 days
14	30 days	14 days

8 CONSULTATIONS: (AS DEFINED IN GENERAL RULE 1.3, 1.4 AND 1.12)

8.1 The need for a consultation can arise as a result of the following:

- a) an unusual or serious clinical problem, and
- b) an Oral and Maxillofacial Surgeon, Dentist or physician requires further advice regarding diagnosis or management, or
- c) the patient, parent or guardian requests another opinion.

8.2 To receive reimbursement as a consultation, communication must exist between a referring physician, Oral and Maxillofacial Surgeon or Dentist and the consultant in the form of:

- a) written communication (consultation request or letter),
- b) documented verbal communication, or

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- c) documented communication between the physician, Oral and Maxillofacial Surgeon or Dentist's agents at the direction of the physician, Oral and Maxillofacial Surgeon or Dentist.

- 8.3 A claim for a consultation must include a valid referring practitioner ID
- 8.4 If a consultation is followed by a procedure performed by the consultant, a benefit may be claimed for the consultation as well as a major procedure, up to and including the day of surgery.
- 8.5 A benefit for continuing care for in-patient hospital services may be claimed by a consultant following a consultation where the continuing care is provided at the request of the referring physician, Oral and Maxillofacial Surgeon or Dentist.
- 8.6 Comprehensive consultations (HSC 03.08D) may only be claimed once every 180 days.
The following exception applies:
- comprehensive consultations provided to patients under 12 months of age may only be claimed once every 90 days,
- 8.7 When an office visit and a hospital admission are provided to a patient on the same day, by the same Oral and Maxillofacial Surgeon or Dentist, only the greater benefit may be claimed.
The following exceptions apply:
a) if a new condition arose and the patient was seen at two separate encounters, both services may be claimed. Documents to support the claim must be submitted,
b) two services may be claimed when they fall within the provisions of General Rule 3.4.
- 8.8 In accordance with GR 5.1, consultations may only be claimed when they are necessary to evaluate conditions requiring special knowledge and skills of the consultant including but not limited to pain, infection, disease, deformity and the prevention of conditions that could impact on the optimal outcome of a medical or surgical procedure as listed in the Schedule of Medical Benefits or Oral and Maxillofacial Surgery Benefits Schedule, including but not limited to head and neck radiation therapy, solid organ transplants, bone marrow transplants, valve replacement surgery etc.

9 SURGICAL BENEFITS:

- 9.1 If more than one related surgical procedure (neither of which is a fracture/disorder repair) is performed through two or more separate incisions by an Oral and Maxillofacial Surgeon or Dentist under one anaesthetic, the benefit for the lesser value procedure may be claimed at 75% of the benefit.
- 9.2 If more than one unrelated surgical procedure is performed by the same Oral and Maxillofacial Surgeon or Dentist through one incision, the benefit for the lesser value may be claimed at 75% of the benefit.
- 9.3 This section does not apply where the lesser or secondary procedure is:
- a fracture that is otherwise provided for in this Schedule,
- a dislocation,
- a procedure considered to be part of an inclusive benefit, or
- a secondary procedure that is paid in full as an additional benefit.

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9.4 The benefit payable for the removal of a lesion includes the biopsy.

9.5 When complex oral and maxillofacial surgery requires the skills of two qualified oral and maxillofacial surgeons, the second surgeon may submit a claim using modifier SOSS for their services when they have actively participated in the planning for and performance of the procedure. Only the second qualified oral and maxillofacial surgeon's surgical time may be claimed; time spent in planning the procedure may not be included in the claimed time. Claims shall indicate the total number of time units spent and may not exceed the anaesthetic time claimed for the procedure. Examples of the types of surgery to be considered for this modifier are complex facial trauma, complex dentofacial and craniofacial deformity surgery, complex reconstructive surgery.

The first 45 minutes of this second surgeon service using modifier SOSS will be one call. Each additional 15 minute block of operating time will be another call. The SOSS modifier is explicit and must therefore be entered on the claim.

If health service codes do not list modifier SOSS in the Price List claims submitted with the SOSS modifier must have supporting information for consideration.

10 SURGICAL ASSISTANCE BENEFITS:

10.1 Claims for surgical assistance must indicate the number of time units the assistant was required. The number of time units claimable for surgical assistance may not exceed that claimed for anesthetic.

10.2 An Oral and Maxillofacial Surgeon or Dentist may claim for either the surgical or surgical assistance service under the same anesthetic, but not both, regardless of the number of procedures performed.

10.3 Surgical assistance may only be claimed when a second Oral and Maxillofacial Surgeon is required during the performance of the following surgical procedures:

15.03A	17.08L	17.08M	17.08N	17.2 E	17.2 F
17.2 G	17.2 H	17.32D	17.5 C		
33.62DA	33.62DB	36.3 K	36.3 L	37.1 DA	37.1 DB
37.2 D	37.91DB	38.21DA	39.52E	39.52F	39.52H
39.52J	39.52DA	39.59B	39.91DC	41.3 C	
88.03B	88.04DB	88.04C	88.09B	88.12DB	88.12DC
88.12DD	88.12F	88.12G	88.12H	88.12J	88.13F
88.13DC	88.13J	88.14DA	88.14DB	88.14DC	88.14J
88.14K	88.14L	88.16DB	88.16C	88.16D	88.19DA
88.29C	88.29E	88.29F	88.29H	88.29M	88.29N
88.29T	88.29U	88.29V	88.29X	88.29Y	88.29CA
88.29DA	88.29DB	88.29DC	88.29DD	88.29DE	88.29DF
88.29DG	88.29DL	88.29DM	88.29DN	88.29FA	88.29GA
88.29HA	88.29MA	88.29TA			

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88.4 DA	88.6 C	88.6 J	88.6 P	88.6 Q	88.6 R
88.6 S	88.6 U	88.6 V	88.6 W	88.6 X	88.6 Y
88.6 Z	88.6 CA	88.6 DA	88.6 EA	88.6 FA	88.71B
88.71C	88.71D	88.76B	88.76DA	88.77A	88.77DA
88.92B	88.92C	88.93D	88.93E	88.93F	88.93G
88.97A					
93.96A	95.02B	98.11DB	98.11DC	98.3 B	98.3 C
98.3 D	98.3 E	98.5 DA	98.51D		

Surgical assists for the following surgical procedures may be claimed by any Dentist:
88.03B 88.04C

10.4 Surgical assistance benefits may not be claimed if an intern or resident is the first assistant.

11 FRACTURES - DISLOCATIONS:

- 11.1 For multiple fractures, 100% of the listed benefit may be claimed for the greater value fracture (open or closed), plus 50% of the benefits for the other fractures treated by closed reduction.
- 11.2 For multiple fractures, the greater value fracture may be claimed at 100% of the listed benefit plus 100% of the benefit for other fractures treated by open reduction, or continuous traction.
- 11.3 A compound fracture treated by either closed or open reduction may be claimed at 150% of the listed benefit.
- 11.4 FRACTURES AND DISLOCATIONS - ATTEMPTED REDUCTION:
- 11.4.1 If an Oral and Maxillofacial Surgeon or Dentist unsuccessfully attempts a closed reduction of a fracture and finds it necessary to transfer the care of the patient to another Oral and Maxillofacial Surgeon or Dentist, the referring Oral and Maxillofacial Surgeon or Dentist may claim up to 50% of the listed benefit for that fracture.
- 11.4.2 The Oral and Maxillofacial Surgeon or Dentist receiving the transferred patient and providing the final reduction may claim 100% of the listed benefit for that fracture.
- 11.5 FRACTURES AND DISLOCATIONS - OPEN REDUCTION FOLLOWING AN ATTEMPTED CLOSED REDUCTION:
- 11.5.1 If the same Oral and Maxillofacial Surgeon or Dentist performs an open reduction following an attempted closed reduction, under the same anesthetic, only the benefit for the open reduction may be claimed.
- 11.5.2 If the same Oral and Maxillofacial Surgeon or Dentist performs an open reduction, following an attempted closed reduction, under a different anesthetic, benefits for both fractures may be claimed.
- 11.6 FRACTURES AND DISLOCATIONS - WITH NON-FRACTURE PROCEDURE:

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11.6.1 If a greater value non-fracture procedure is performed at the same time as a lesser value fracture, payment will be as follows:

- greater value non-fracture - 100% of base rate,
- lesser value closed reduction of fracture - 50% of base rate,
- lesser value open reduction of fracture - 100% of base rate

11.6.2 If a lesser value non-fracture procedure is performed at the same time as a greater value fracture, payment will be as follows:

- greater value closed reduction of fracture - 100% of base rate,
- greater value open reduction of fracture - 100% of base rate,
- lesser value non-fracture procedure through different incision - 75% of base rate,
- lesser value non-fracture procedure through same incision - 75% of base rate.

12 BONE GRAFTS:

12.1 The following rules apply to procedures performed on the same patient, under the same anesthetic:

12.1.1 benefits for bone grafts include harvesting and osteotomy,

12.1.2 when a bone graft must be taken to fill a defect and is performed in association with an open reduction of a fracture, 100% of the listed benefit may be claimed for the fracture, in addition to 100% of the benefits for health service codes 88.29DH, 88.29DJ or 88.29DK.

12.1.3 when a bone graft is required to fill a defect for open reduction and mini plate fixation of facial fractures, 75% of the listed benefit for health service code 88.97A may be claimed in addition to 100% of the benefit for the fracture.

12.1.4 Bone graft harvesting (88.29DH, 88.29DJ and 88.29DK) may be claimed as a stand alone procedure.

12.1.5 Bone graft harvesting (88.29DH, 88.29DJ and 88.29DK) can be paid at 100% in addition to the following health service codes:

17.32D	33.76DG	33.76DH	34.61A	34.61B	34.61C
34.61D	34.61E	34.61F	36.3 G	36.3 H	36.3 J
36.3 K	36.3 L	39.52E	39.52F	39.52H	39.52J
39.52DA					

88.29H	88.29M	88.29T	88.29V	88.29X	88.29Y
88.29DB	88.29DE	88.29DG	88.29CA	88.29DA	88.29DL
88.29DM	88.29DN	88.29N	88.29FA	88.29GA	88.29HA
88.29TA	88.29MA	88.4 DA	88.6 X	88.6 DA	88.6 EA
88.6FA	88.76B	88.76DA	88.77A	88.77DA	88.97A

13 CONCURRENT CARE - IN-HOSPITAL: (AS DEFINED IN GENERAL RULE 1.5)

13.1 If the services of more than one Oral and Maxillofacial Surgeon or Dentist are required because of the complexity of the clinical needs of a patient, each Oral and Maxillofacial Surgeon or Dentist may claim a benefit for concurrent care. Documentation to support the claim must be submitted.

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- 13.2 If a consultation is required, the attending Oral and Maxillofacial Surgeon or Dentist and the consultant may each claim for services provided on the day of consultation.
- 13.3 A benefit may be claimed by the referring Oral and Maxillofacial Surgeon or Dentist only after the full responsibility for the care of the patient has been returned to him, or the complexity of the patient's condition requires the services of the referring Oral and Maxillofacial Surgeon or Dentist in addition to the consultant.
- 13.4 When the care of the patient remains with the referring physician, Oral and Maxillofacial Surgeon or Dentist, and the nature of the illness makes further intermittent visits by the consultant advisable, they may not be claimed as minor consultations. These in-patient services may be claimed as hospital visits.
- 14 TRANSFER OF CARE: (AS DEFINED IN GENERAL RULE 1.12)
- 14.1 If the care of a patient is transferred, each Oral and Maxillofacial Surgeon or Dentist may claim for services provided on the day of transfer.
- 14.2 An Oral and Maxillofacial Surgeon or Dentist who admits a patient to hospital and provides pre-operative hospital care, but does not perform the surgery, may claim for services up to and including the day of surgery.
- 14.3 Patient Transfer Within Same Facility:
- 14.3.1 Treatment of Same Illness:
If a patient is transferred for treatment of the same illness, the benefit payable to the receiving Oral and Maxillofacial Surgeon or Dentist will be determined by the number of days of the patient's hospitalization.
- 14.3.2 Treatment of New Illness:
If the transfer of care is due to the onset of a significant new illness, the receiving Oral and Maxillofacial Surgeon or Dentist may claim daily hospital care, starting at the benefit payable for the first day of hospitalization.
- 14.4 Patient Transfer To Different Facility:
If a patient is transferred to another hospital to the care of another Oral and Maxillofacial Surgeon or Dentist, hospital care may be claimed as though it were a new admission.
- 15 PROCEDURES:
- 15.1 The following rules apply to services provided to the same patient, by the same Oral and Maxillofacial Surgeon or Dentist during the same encounter:
- 15.1.1 only the greater benefit of a minor procedure, consultation or visit may be claimed unless each service is for an unrelated diagnosis,
- 15.1.2 only the greater benefit for a minor procedure (m or m+) or a hospital visit may be claimed regardless of the diagnosis,

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- 15.2 If a minor "+" procedure is performed in an Oral and Maxillofacial Surgeon's or Dentist's office, or surgical suite, both the procedure and the appropriate office visit may be claimed regardless of the diagnosis.
- 15.3 Only the greater benefit of a minor "+" procedure or a visit may be claimed when they are performed in a location other than an Oral and Maxillofacial Surgeon's or Dentist's office, or surgical suite, regardless of the diagnosis.
- 15.4 If a minor "+" procedure and a consultation are provided, both benefits may be claimed, regardless of the location of the services.
- 15.5 If a minor "+" and a consultation benefit are claimed, an office visit may not be claimed in addition, regardless if the services are provided at different times. Refer to General Rule 1.9 - Definition of Encounter.
- 16 MAJOR PROCEDURES: (REFER TO GENERAL RULE 7.2)
- 16.1 Health service codes with a designated category code of 4, and 14 include both related pre-operative and post-operative services. The following are exceptions:
- a consultation benefit may be claimed up to and including the day of surgery.
 - pre-operative hospital care may be claimed for attempted conservative treatment by the dental surgeon if documentation detailing that conservative treatment is submitted.
 - removal of arch bar splint
- 16.2 Benefits may be claimed as applicable for complications occurring during the post-operative time periods.
- 16.3 Where a procedure is performed under general anaesthesia the following applies to procedural benefits listed under General Rule 16.3.5:
- 16.3.1 if the procedure is the only procedure performed at that time, a benefit of \$117.12 may be claimed,
- 16.3.2 if another procedure is performed at the same encounter and its listed benefit is greater than \$117.12 the Oral and Maxillofacial Surgeon or Dentist may claim that listed benefit plus a percentage of the listed benefit for the lesser procedure(s) calculated in accordance with this Schedule. The \$117.12 minimum benefit may not be claimed for the lesser procedures,
- 16.3.3 if multiple procedures are performed at the same encounter and the listed benefit for each of them is less than \$117.12 the Oral and Maxillofacial Surgeon or Dentist may claim a benefit of \$117.12 for the greater procedure plus a benefit for each of the lesser procedures that is a percentage of the listed benefit calculated in accordance with this Schedule. The \$117.12 minimum benefit may not be claimed for the lesser procedures,
- 16.3.4 if multiple procedures are performed at the same encounter and only one of them appears under General Rule 16.3.5, the Oral and Maxillofacial Surgeon or Dentist may claim a benefit of \$117.12 for that procedure plus a benefit in respect of each of the other procedures that is a percentage of the listed benefit and calculated in accordance with this Schedule,

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16.3.5 General Rule 16.3 applies to the following health service codes:

01.01DA	17.7 B	33.02DB	33.61B	34.1 B	36.3 B
36.7 A	36.7 B	37.81D	38.0 B	38.0 D	38.19A
38.19B	38.91A	39.0 C	39.1 A	39.21C	39.41
39.83C	46.04DA				

88.29NA	88.29QA	88.29RA	88.29SA	88.81A	88.92B
88.92C	88.95A	98.12DN	98.3 A	98.6 DA	98.6 DC

16.4 General Rule 16.3 does not apply to surgical assistance or anesthetic benefits.

16.5 If an Oral and Maxillofacial Surgeon or Dentist does not provide the major portion of the post-operative care, the surgical benefit may be reduced to a lesser rate than listed for the procedure.

16.6 An Oral and Maxillofacial Surgeon or Dentist, providing the post-operative care under General Rule 16.5 may submit claims on a fee for service basis.

17 BENEFITS FOR UNSCHEDULED SERVICES/SPECIAL CALLBACKS:

17.1 Unscheduled Services/Special Callbacks - Hospital In-Patient, Out-Patient and Emergency Departments:
Benefits for UNSCHEDULED services are intended to cover a degree of disruption that an Oral and Maxillofacial Surgeon or Dentist would have to experience to provide such services during:

- a) the evening, on weekdays (1700 - 2200 hours),
- b) during the day and evening on weekends and statutory holidays (0700 - 2200 hours), and
- c) during any night of the week (2200 - 0700 hours).

17.2 In situations where the service is initiated by the Oral and Maxillofacial Surgeon or Dentist, the unscheduled service or special callback benefits may not be claimed.

17.3 Only one unscheduled service or special callback benefit may be claimed for each encounter with a patient.

17.4 The unscheduled service and special callback benefit must be claimed according to the time at which the encounter commences and not from the time of the call for attendance.

17.5 Claims For Unscheduled Services/Special Callback Benefits:

17.5.1 Claims for unscheduled service benefits must meet all of the following conditions:

- a) a special call for attendance is made on the patient's behalf,
- b) the Oral and Maxillofacial Surgeon or Dentist responds to such a call on an unscheduled basis outside of his/her normal working hours,
- c) the patient is attended on a priority basis, and
- d) there is direct attendance by the Oral and Maxillofacial Surgeon or Dentist.

17.5.2 Claims for special callbacks must meet all of the following conditions:

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- a) a special call for attendance is made on the patient's behalf,
- b) the Oral and Maxillofacial Surgeon or Dentist responds to such a call from outside the hospital, on an unscheduled basis,
- c) the patient is attended on a priority basis, and
- d) there is direct attendance by the Oral and Maxillofacial Surgeon or Dentist.

17.6 Special callback benefits may not be claimed for subsequent patients seen during the same callback or in association with another service during the same encounter.

17.7 The unscheduled service benefit (modifier SURC) may be claimed for the following services:
- consultations, including telehealth services

17.8 The unscheduled service benefit (modifier SURC) may not be claimed for:

17.8.1 Stand-by time,

17.8.2 Additional procedures, i.e. that which are performed in association with another procedure,

17.8.3 Services with the category code "V", except for consultations, including telehealth services, and

17.8.4 Services included in the following list, unless supporting information detailing unusual circumstances satisfactory to the Minister is provided:

13.4 B	13.59DE	13.59DF	13.59DH	13.59DJ	13.59DK
17.1 E	17.7 A	17.7 B	17.7 C	36.3 B	36.3 C
36.3 D	36.3 E	36.3 M	36.3 F	36.3 G	36.3 H
36.3 J	36.3 K	36.3 L	36.7 A	36.7 B	37.49A
37.99B	38.0 B	38.0 C	38.0 D	38.19A	38.19B
38.19D	38.91A	39.21B	39.21C	39.52E	39.52F
39.52H	39.52J	39.52DA	39.59B	39.83C	39.83D
39.99B	39.99C	88.29DC	88.6 C	88.6 J	88.6 FA
88.6 P	88.6 Q	88.6 R	88.6 S	88.6 U	88.6 V
88.6 W	88.6 X	88.6 Y	88.6 Z	88.6 CA	88.6 DA
88.6 EA	88.81A	88.95A	98.12DN	98.3 A	98.6 DA
98.6 DB	98.6 DC	98.6 DD	98.6 DE	98.6 DF	98.6 DG

18 EFFECTIVE DATE OF SCHEDULE:

18.1 Deleted

19 BENEFITS FOR INTENSIVE CARE SERVICES (ICU).

19.1 Benefits for unscheduled services may be claimed according to GR 17.

19.2 Health service code 03.05DE may be claimed for time spent with a patient on a cumulative basis per day (defined as 0001 to 2400).

19.3 When a consultation is claimed in association with 03.05DE during the same encounter - the consultation is considered to occupy the first 30 minutes of time spent with the patient.

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19.4 When a procedure and an ICU visit (03.05DE) are provided at the same encounter, only the greater benefit may be claimed.

19.5 Procedures performed in ICU are payable as follows:

- a) the same encounter - the greater procedure at 100% and other procedures at 75% unless otherwise specified in the Schedule.
- b) to obtain payment at 100% for two or more procedures on the same date of service, the claim must indicate that the service was performed at a separate encounter.

20 RECONSTRUCTIVE SURGERY

20.1 DEFINITIONS

20.1.1 FUNCTIONAL AREA

Functional area includes the following anatomical areas: Head, face & neck and includes coverage of exposed vital structures (bone, tendon, major vessel, nerve).

20.1.2 TYPES OF INJURY

- a) Acute: Primary - refers to procedure within 10 days of injury,
- b) Subacute: Secondary - refers to procedure within 11 - 21 days of injury,
- c) Chronic: refers to procedures more than 21 days after injury.

20.2 GRAFTS

20.2.1 When multiple grafts are applied within the same anatomical area, the total number of square centimetres per anatomical area may be claimed.

20.2.2 When grafts are applied to multiple anatomical areas payment will be as follows:

- a) first anatomical area - 100% of listed benefit
- b) second and subsequent anatomical area(s) - 75% of the listed benefit.

20.3 FLAPS AND TISSUE RESECTION

20.3.1 Multiple flaps (non z-plasty flaps) are claimed at 100% of the listed benefit for the first and 75% of the listed benefit for each subsequent flap. A donor defect resulting from a major flap, which requires a skin graft or pedicle flap greater than 5 cms is claimed at 75% of the listed benefit.

20.3.2 Benefits for tissue resection required prior to reconstruction may be claimed in addition to the benefits for reconstruction. The greater benefit may be claimed at 100% and the lesser at 75%. Only one tissue resection benefit may be claimed per anatomical area.

21 ORAL MAXILLOFACIAL SURGEON TO PHYSICIAN OR DENTIST TELEPHONE ADVICE

21.1 This service includes the recording of a history review, history of presenting complaint, pertinent family and/or patient history where indicated, discussion of patient condition/management including review of laboratory and other data where indicated, the diagnosis/assessment provided by telephone to the referring physician or dentist and documentation.

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21.2 When claiming for this service the consultant is expected to provide an opinion and recommendations for patient treatment as well as management to the referring practitioner.

22 DENTAL/ORAL SURGICAL RELATED ANAESTHETIC SERVICES

22.1 The appropriate listed anaesthetic benefit or the number of time units for the procedure may be claimed by a Physician anaesthetist when the oral surgical procedure is listed under the Schedule of Oral and Facial Surgery Benefits, whether it is being performed in an active treatment hospital or in non-hospital surgical facilities, accredited by the College of Physicians of Alberta.

22.2 Dental anaesthetic services 36.99A, 36.99B and 36.99C, performed by a physician anaesthetist, are insured only when one of the following criteria is met:

22.2.1 The patient has a severe mental or physical disability that precludes the performance of the dental procedure under local anaesthetic or;

22.2.2 The presence of dental disease adds a significant risk of complications to a planned open cardiac or organ transplant procedure or;

22.2.3 A child requires extensive dental rehabilitation and could not otherwise be treated due to the length of time for the treatment.

22.3 Claims for anaesthetic services for intravenous sedation and physiologic monitoring, by a physician anaesthetist, may be claimed as benefit items 36.99A, 36.99B or 36.99C for patients in hospital, when such services are medically required.

23 LABORATORY OR PATHOLOGY SERVICES

23.1 The preparation, submission and interpretation of culture and biopsy specimens is included in the fee paid for the surgical procedure.

23.2 Discussion of the significance of biopsy or culture results with the patient is also included in the fee paid for the surgical procedure.

23.3 No fee should be charged to the patient for the pathology tests done on biopsy or surgical excision specimens. This is a service included in the coverage provided by Regional Health Authorities.

24 SURGERY ON THE NOSE

24.1 Submucous resection of the nasal septum may only be claimed in association with:

- cleft maxilla repair
- trauma
- orthognathic surgery

24.2 Closed reduction of a nasal fracture may only be claimed when another insured service has also been provided. It is not claimable for cosmetic purposes (see GR 5.3 and 5.4).

24.3 Open reduction of a nasal fracture

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- 24.3.1 by external or sinusal approach may only be claimed if performed in conjunction with other insured facial fractures
- 24.3.2 by orbital approach with insertion of subperiosteal implant may only be claimed in association with:
- cleft maxilla repair
 - trauma
 - orthognathic surgery
- 24.3.3 and miniplate fixation or miniplate fixation via coronal approach may only be claimed when performed in conjunction with another major surgical procedure due to trauma
- 24.4 Other rhinoplasty or septoplasty (items 33.76DA to 33.76DF) may only be claimed when performed in conjunction with
- another insured oral surgical procedure
 - the treatment of a trauma injury

25 TELEHEALTH

- 25.1 TELEHEALTH EXAMINATION - DEFINITION
Telehealth examination means an examination of a patient by the consultant at the receiving site, using "telehealth services" as defined under GR 1.14 but does not include the "physical examination" requirements referred to under GR 1.3 and 1.4.
- 25.2 Health service code 03.01DC may only be claimed if the Oral Maxillofacial Surgeon or Oral Pathologist is required to be present at the referring site to assist with essential physical assessment without which the consultant service would be ineffective.
- 25.3 Health service code 03.01DC may be claimed in addition to other services provided in an emergency situation.
- 25.4 Telehealth services provided at the request of a non-physician other than a dentist may not be claimed.
- 25.5 Services claimed using the telehealth modifier must meet all of the requirements outlined in the applicable GR's 1.3 & 1.4.