ALBERTA HEALTH CARE INSURANCE PLAN

Podiatry

Governing Rules List

As Of

01 June 2006

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1 DEFINITIONS

This document, entitled the Schedule of Podiatry Benefits is hereinafter referred to as "Schedule". This Schedule applies only to those services that are insured under the Alberta Health Care Insurance Act. These rules apply to all benefits unless otherwise stated. The rates for anaesthetic services and modifiers ANE, ANEST, ANEU, ANU, EV, NTAM, NTPM, WK, listed in the Schedule of Podiatric Benefits are payable to physicians and are not claimable by podiatrists.

1.1 In this Schedule, "certificate of registration" means a certificate of registration as defined in section 18.4 of the Health Insurance Premiums Act;

1.2 "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, Boxing Day;

1.3 where a holiday falls on a Saturday or Sunday the Minister shall designate another day as the holiday;

1.4 "benefit year" means July 01 of one year to June 30 of the following year.

1.5 "home" includes patient's home, group homes, seniors lodges, personal care homes and other residences as approved, but does not include auxiliary hospitals or nursing homes.

1.6 "Family" means children, siblings, parents, spouse and interdependent partner;

2 ANNUAL LIMITS

2.1 Subject to the Alberta Health Care Insurance Regulation (Alberta Reg.216/81) and the Claims for Benefits Regulation (Alberta Reg.204/81) the benefits for insured services provided by a podiatrist inside or outside Alberta are limited as follows:

2.1.1 to a benefit maximum of $250.00 for each individual per benefit year effective on or after November 15, 1993.

2.2 W.C.B. claims are excluded from the limit in General Rule 2.1.1.

3 APPLICATIONS

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

3.2 When multiple services are provided from both the Schedule of Podiatry Benefits and the Schedule of Podiatric Surgery Benefits to the same patient at the same encounter, then applicable governing rules apply even though the services are from two different schedules. Refer to the governing rules in the Schedule of Podiatric Surgery Benefits.

3.2.2 This Schedule has been modelled after the Schedule of Medical Benefits and therefore uses the same categories and terminology. Notwithstanding, podiatrists cannot perform or claim for procedures that are outside the podiatric scope of practice (eg. operations on cranial nerves).

3.3 CATEGORY CODES

3.3.1 All benefit items in the Schedule are assigned a category code as follows:

- V - Visit
- T - Test
- T+ - Test
- M - Minor Procedure
- M+ - Designated Minor Procedure
- 1-13 - Major Procedure

The pre-operative and post-operative periods for major procedures are detailed in Rule 6.8.1.

3.3.2 Benefit items with a T+ category code are considered to be tests; however, they may be claimed in the same way as designated minor procedures. Please refer to Rule 6.6.

3.4 CLAIMS FOR BENEFITS

3.4.1 A claim must be submitted in the format prescribed by the Minister.

3.4.2 Rule 3.4.1 applies whether the claim is submitted by a podiatrist on behalf of a patient or by the patient.

3.4.3 For administrative purposes the start of the day is considered to be 1200 AM (midnight). Notwithstanding this, if a home visit is provided between midnight and 8.00 AM, a hospital visit service also may be claimed after 8.00 AM on the same day.

3.4.4 Claims may not be submitted more than 180 days from the date of service unless:

a) they relate to hospital in-patients, in which case the claim must be submitted within 180 days from the last date of hospital service.

b) evidence of extenuating circumstances, satisfactory to the Minister, is provided.

3.4.5 Claims may be submitted by a podiatrist who is present and supervising a podiatry resident during the provision of a service.

4 EXCLUSIONS

Exclusions under the Alberta Health Care Insurance Act include but are not limited to the following:

4.1 THIRD PARTY SERVICES

Examinations or services required to provide reports or certificates requested by a third party are not an insured service, eg.:

Adoption
Judicial Purposes

Attendance at Camp
Autopsies
Employment
Insurance/disability
Family & Social Services
University or Other School Entrance
(examinations/procedures requested by police)
Motor Vehicle License (except after the age of 75)
Participation in Sports
Passport or Visa
Immigration Requirements

4.2 MATERIALS AND OTHER SERVICES

The following are not a benefit under the Plan:

Advice by telephone
Ambulance services
Drugs/Agents
Medical testimony in court (with the exception of psychiatric opinion at psychiatric review panel under the Mental Health Act)
Anaesthetic materials
Medical appliances
Secretarial or reporting fees
Travel time of a practitioner to see a patient
Stand by time
Any service a practitioner provides to a member of his or her own family
Oculo-visual examination for residents aged 19 through 64 years

4.3 Benefits may not be claimed by a surgeon, surgical assistant or anaesthetist with respect to a procedure performed for cosmetic reasons.

4.4 Benefits may not be claimed by a 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.

4.5 After a diagnosis has been established, further services - such as preoperative tests, consultations, anaesthetics or surgical assists - associated with an uninsured service also are not insured. Examples of uninsured services include:

Radial Keratotomy
In Vitro fertilization
Artificial insemination
Ovarian stimulation
Sperm transfer (OSST)
Gamete transfer (GIFT)
EDTA chelation therapy
Acupuncture

4.6 Surgical procedures which are not medically required are not insured services and claims should not be submitted.

5 VISITS AND CONSULTATIONS

5.1 COMPLETE EXAMINATION - DEFINITION:

In the context of Rule 5, complete physical examination shall include examination of each organ system of the body, except in psychiatry, dermatology, the surgical specialties and podiatry. "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.

5.2 VISITS - DEFINITIONS

5.2.1 Brief Visit: Assessment of a patient's condition when history is minimal and little or no physical examination is included.

5.2.2 Limited Visit: A limited assessment, of a patient, which includes a history limited to and related to the presenting problem, and an examination which is limited to relevant body systems, an appropriate record, and advice to the patient. It includes the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient.

5.2.3 Comprehensive Visit: An in-depth evaluation of a patient. This service includes the recording of a complete podiatric history and performing a complete podiatric physical examination, 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.

5.3 CONSULTATIONS - DEFINITIONS

5.3.1 Comprehensive Consultation: An in-depth evaluation of a patient with a written report to the referring podiatrist or physician. This service includes the recording of a complete podiatric history, performing a complete podiatric physical examination, 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 and the referring podiatrist or physician.

5.3.2 Limited Consultation: Limited assessment of a patient and a written report to the referring podiatrist or physician. A limited consultation includes a history limited to and related to the presenting problem, and an examination which is limited to relevant body systems, 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 and the referring podiatrist or physician.

5.4 CONSULTATION - APPLICATION

5.4.1 In this Schedule "consultation" means that situation where a podiatrist or a physician after an appropriate examination of the patient, requests the opinion of a podiatrist and the consultant does a history and examination and review of the diagnostic data and provides a written opinion with recommendations as to the treatment, to the referring podiatrist or physician. Consultations may not be claimed for transfer of care alone.

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

a) some unusual or serious clinical problem,

b) a podiatrist or physician requires further advice regarding diagnosis or management, or both, or
c) the patient, parent or guardian requests another opinion.

5.4.3 A referral may be accepted from any person; however, to receive reimbursement as a consultation, communication must exist between a referring podiatrist or physician and the consultant in the form of:
a) written communication (consultation request or letter),
b) verbal communication, or
c) communication between podiatrists' and/or physicians' agents at the direction of the podiatrists and/or physicians.

5.4.4 Notwithstanding Rules 6.6.4 and 6.8.3, 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 if the time interval between the major surgical procedure and the preceding consultation is greater than 14 days.

5.4.5 A benefit for continuing care may be claimed by a consultant following a consultation where the continuing care is provided at the request of the referring podiatrist or physician.

5.4.6 Repeat consultations may not be claimed unless a further request has been initiated by and received from the referring podiatrist or physician for another consultation. A repeat consultation is not appropriate if initiated by the consultant.

5.4.7 When a podiatrist sends a member of his family to another podiatrist, a consultation benefit may not be claimed.

5.4.8 CLAIMS REQUIRING REFERRING PRACTITIONER NUMBER

When a claim is submitted for consultation services 03.07AB and 03.08AA, the referring practitioner field must be completed with a valid referring practitioner number.

5.5 LIMITATION ON VISITS AND CONSULTATION DESCRIBED AS COMPREHENSIVE

5.5.1 A podiatrist may only claim for a consultation or a comprehensive visit under HSCs 03.04AA or 03.08AA found in the Schedule of Podiatry Benefits for the same patient once in a 180 day period.

5.5.2 A podiatric surgeon may only claim for a consultation or a comprehensive visit uner HSCs 03.04PA, 03.04AA, 03.08AA, 03.08PA, 03.08PB, or 03.08PC found in the Schedule of Podiatry Benefits or the Schedule of Podiatric Surgery Benefits for the same patient once in a 180 day period.

5.6 TRANSFER OF CARE

5.6.1 If the care of a patient is transferred, each practitioner may claim for services provided on the day of transfer.

5.6.2 Transfer of care is a situation where a patient is transferred to another podiatrist for care and where the transferring podiatrist will not be involved in the follow up treatment/care provided by the receiving podiatrist. In such instances the opinion or advice of the receiving podiatrist is not required by the transferring podiatrist. A report is not required by the transferring podiatrist, therefore a claim for a consultation by the receiving podiatrist is not appropriate.

6 PROCEDURES

6.1 If a podiatrist performs a procedure and provides a service warranting a claim for an office visit or a home visit on the same day, benefits for both may be claimed only if the services and diagnoses are unrelated.

6.2 If a service is provided in a hospital emergency department, only the procedural or the visit benefit, whichever is the greater, may be claimed, unless the problems are emergencies and the diagnoses are unrelated.

6.3 A procedure benefit includes removal of sutures. The podiatrist who placed sutures may not claim for removing them. A second podiatrist who is in the same practice group as the surgeon may not claim for removing the sutures either. However, a second podiatrist may claim a visit for removal of sutures if he is not a member of the same practice group as the podiatrist who put the sutures in.

6.4 Anaesthetic benefits for local infiltration are included in the benefit for the procedure.

6.5 NON-INVASIVE DIAGNOSTIC PROCEDURES IN HOSPITAL

Benefits for non-invasive diagnostic procedures performed for a hospital in-patient or registered out-patient are not payable under the Schedule. Payment for these services are the responsibility of the hospital. This applies to both the technical and professional components.

6.6 DIAGNOSTIC SURGICAL PROCEDURES

6.6.1 If a patient is admitted to a hospital for the purpose of undergoing a procedure designated "+", a benefit is payable for a visit provided the day before or the day after the procedure is performed, but if the procedure is performed and a visit occurs on the same day, a benefit is payable for either the procedure or the visit, but not both.

6.6.2 If a procedure designated "+" is performed in a podiatrist's office, both the procedural benefit and the appropriate office visit benefit for that day may be claimed, but if a consultation benefit pursuant to Rule 6.6.4 has been claimed, a visit benefit will not be payable for the day on which the procedure is performed.

6.6.3 If a procedure designated "+" is performed in a place other than a podiatrist's office, either a procedural benefit or a visit benefit, but not both, may be claimed for that day. A consultation benefit pursuant to Rule 6.6.4 is also payable for that day.

6.6.4 If a procedure designated "+" and a consultation are provided on the same day, both the procedural benefit and the appropriate consultation benefit are payable.

6.7 MINOR PROCEDURES

6.7.1 If a minor procedure (M or M+) is provided with a hospital visit on the same day, only the greater benefit item may be claimed.

6.7.2 When more than one procedure with a "V" category is provided at the same encounter only the greater benefit may be claimed.

6.8 MAJOR PROCEDURES

6.8.1 Major procedure benefit items with designated category codes 1-13 include related pre-operative and post-operative services. The following chart gives the pre-operative and post-operative periods.

Category	Pre-Operative	Post-Operative
1	0 - Days	14 - Days
2	0 - Days	42 - Days
3	7 - Days	7 - Days
4	7 - Days	14 - Days
5	7 - Days	42 - Days
6	14 - Days	14 - Days
7	14 - Days	28 - Days
8	30 - Days	42 - Days
13	0 - Days	21 - Days

6.8.2 Notwithstanding anything in this section, where complications occur during or following the periods prescribed in 6.8.1, applicable benefits may also be claimed.

6.8.3 Notwithstanding rule 6.8.1 and in accordance with rule 5.4.4,

a) a benefit for a consultation may be claimed providing the interval between the major surgical procedure and the preceding consultation is greater than 14 days and

b) pre-operative hospital care may be claimed by the podiatrist who performed the surgery if information is submitted to show that conservative treatment was attempted before surgery was performed.

6.8.4 If a podiatrist 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.

6.8.5 The podiatrist providing the post-operative care under Rule 6.8.4 may submit claims on a fee for service basis.

6.9 MULTIPLE PROCEDURES

6.9.1 If 2 similar procedures are performed at one time, the 2nd procedure may be claimed at 75% of the listed benefit unless otherwise indicated in the schedule.

6.9.2 If 2 different procedures are performed by one podiatrist through separate incisions under one anaesthetic, the claim for the lesser procedure may be claimed at 75% of the listed benefit.

6.9.3 If 2 unrelated procedures are performed through the same incision, the benefit for the lesser procedure may be claimed at the rate of 75% of the listed benefit.

6.9.4 If 2 unrelated procedures are performed by 2 podiatrists in different anatomical areas utilizing the same anaesthetic, the benefit for each procedure may be claimed according to the listed benefit.

6.9.5 If multiple related procedures are performed through one incision, by one podiatrist, a benefit may be claimed for the major procedure only.

6.9.6 The section on multiple procedures does not apply where the lesser or secondary procedure is:

a) a fracture that is otherwise provided for in this Schedule,
b) a dislocation,
c) a procedure considered to be part of an inclusive benefit, or
d) a secondary procedure that is paid in full as an additional item or as an interpretation of a diagnostic test as a listed benefit in the Schedule.

6.9.7 Unless otherwise stated in the schedule, if a surgical procedure and related diagnostic procedure are performed by the same podiatrist, utilizing the same anaesthetic, only the greater benefit may be claimed.

6.9.8 Claims may not be submitted for incidental procedures.

6.10 BILATERAL SURGERY - TWO PODIATRISTS

When two podiatrists operate on two sides at the same time, the surgeon most responsible for the patient's care should claim 100% of the listed fee for the procedure she/he performs and the second surgeon should claim 75% of the fee for the procedure she/he performs.

6.11 FRACTURES AND DISLOCATIONS

6.11.1 For a compound fracture (closed reduction only), 150% of the listed benefit may be claimed.

6.11.2 For an uncomplicated fracture without displacement, only 50% of the listed benefit may be claimed.

6.11.3 For multiple fractures, a full benefit may be claimed for the major fracture plus 50% of the benefits for the other fractures treated by closed reduction.

6.11.4 A benefit may be claimed at the full rate for each fracture which requires open reduction.

6.11.5 Where a bone graft must be taken to fill a defect and is performed in association with an open reduction of a fracture, the fracture may be claimed in full as well as item 90.09AA, 90.09AB, 90.09AC.

6.11.6 Fees for bone grafts include harvesting.

6.11.7 The benefit for the bone graft procedure includes the osteotomy component. If a bone graft benefit (all codes 90.0) and an osteotomy benefit (all codes 89.0, 89.3 and 89.4) are claimed at the same encounter, only the greater benefit may be paid.

6.12 FRACTURES AND DISLOCATIONS - ATTEMPTED REDUCTION

6.12.1 If a podiatrist attempts a closed reduction of a fracture unsuccessfully and finds it necessary to transfer the care of the patient to another podiatrist, the referring podiatrist may claim up to 50% of the benefit listed for such fractures.

6.12.2 The listed benefit may be claimed by the podiatrist receiving the transferred patient and providing the final reduction.

6.13 FRACTURES AND DISLOCATIONS - OPEN FOLLOWING CLOSED REDUCTION

6.13.1 If the same podiatrist performs an open reduction following an attempted closed reduction, under the same anaesthetic, only the benefit for open reduction may be claimed.

6.13.2 If the same podiatrist performs an open reduction following an attempted closed reduction, under a different anaesthetic, benefits for both may be claimed.

6.14 SAME PODIATRIST, TWO FUNCTIONS

6.14.1 A podiatrist acting as both a surgical assistant and a surgeon for separate procedures under one anaesthetic may submit a claim for both services.

7 RECONSTRUCTIVE PLASTIC SURGERY

7.1 DEFINITIONS

7.1.1 FUNCTIONAL AREA

Functional area includes the following anatomical areas: Head, face, neck, axilla, elbow, wrist, hand, groin, perineum, knee, ankle, foot, and includes coverage of exposed vital structures (bone, tendon, major vessel, nerve).

7.1.2 NON - FUNCTIONAL AREA

Non-functional area includes the following anatomical areas: Posterior trunk, anterior trunk, and each of the extremities.

7.1.3 TYPES OF INJURY

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

7.2 GRAFTS

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

7.2.2 When grafts are applied to multiple anatomical areas, whether non-functional or functional, 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, except extensive grafts which are paid at 100%.

7.3 FLAPS AND TISSUE RESECTION

7.3.1 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.

7.3.2 Tissue resection required prior to reconstruction should be claimed at 100% of the greater benefit (resection or reconstruction) and 75% of the lesser benefit. However, only one tissue resection may be claimed per operation.

8 DIAGNOSTIC IMAGING

8.1 The benefit for any one region is intended to cover a sufficient number of films to establish a diagnosis in the ordinary case.

8.1.1 Films taken prior to and subsequent to the reduction of a fracture may be claimed in full.

8.1.2 Benefits are intended for diagnostic or therapeutic purposes and are not intended for mass screening.

8.2 EXTREMITIES

Limited bilateral examination for conditions such as arthritis, gout, epiphysial development, etc., may be claimed as one such region and the unilateral fee shall apply.

8.3 COMPARATIVE VIEWS

If imaging of a contralateral joint or extremity for comparative views is necessary on clinical grounds then an additional 50% may be claimed for the second side.

8.3.1 Soft tissue examinations may be claimed as for a single area of the adjacent bone or joint.

8.3.2 A foot and ankle examination may constitute two separate benefits.

9 SURGICAL ASSISTANCE BENEFITS

9.1 Claims for surgical assists shall indicate the number of time units the assistant was required. The number of units of time submitted for surgical assists shall not exceed that for anaesthetic.

9.2 Surgical assistance benefits may not be claimed if a podiatry resident is the first assistant.

9.3 Benefits may not be claimed for procedures that do not routinely require the services of a surgical assistant unless supporting information detailing unusual circumstances satisfactory to the Minister is provided. Such procedures include but are not limited to the following list:

07.27AB	07.29AA	07.29AB	07.53AD	07.53AE	07.56AA
07.57AA	07.57AB	13.59AA	17.71AA	17.81AA	91.06AB
91.06AD	91.06AE	91.07AA	91.77AC	93.91AB	95.03AA
95.81AA	95.96AA	96.11AA	98.03AA	98.04AA	98.04AB
98.12AA	98.12AJ	98.12AK	98.12AL	98.22AA	98.96AA
98.96AB	98.96AC	98.96AD	98.96AE		