

Medical
Governing Rules List
As Of
01 June 2006

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Schedule of Medical Benefits
Part A - General Rules

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1 DEFINITIONS

This document, entitled the Schedule of Medical 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 General Rules (GRs) apply to all benefits unless otherwise stated.

- 1.1 In this Schedule, "certificate of registration" means a health insurance card issued under the Health Insurance Premiums Act to a resident of Alberta, or any other document prescribed as a "certificate of registration" for the purposes of the Health Insurance Premiums Act and the Medical Benefits Regulation.
- 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 "physician" includes "osteopath";
- 1.5 "benefit year" means July 01 of one year to June 30 of the following year.
- 1.6 For the purposes of billing home visits, "home" includes personal residence or temporary lodging, assisted living, designated assisted living, group home, seniors' lodge, personal care home and other residences as approved, but does not include auxiliary hospitals or nursing homes.
- 1.7 "family" means children, siblings, parents, spouse and adult interdependent partner.
- 1.8 "Home Care Worker" is defined as a Registered Nurse, Licensed Practical Nurse, Psychiatric Nurse, Occupational Therapist, Physiotherapist, Respiratory Therapist, or any other profession under the Health Professions Act working in an Alberta home care program or Alberta palliative care program administered by a Regional Health Authority established under the Regional Health Authorities Act (RSA-9.07).
- 1.9 "Community Mental Health Care Worker" is defined as a Registered Nurse, Licensed Practical Nurse, Psychiatric Nurse, Social Worker, Psychologist or any other profession under the Health Professions Act working in an Alberta community mental health care program administered by a Regional Health Authority or the Provincial Mental Health Advisory Board established under the Regional Health Authorities Act (RSA-9.07).
- 1.10 "Telehealth" service is defined as a physician delivered health service through the use of videototechnology, including store and forward, that is provided to a patient who is in attendance at a designated RHA telehealth site at the time of the video capture. Telehealth services do not include teleradiology.
- 1.11 "Videotechnology" means the recording, reproducing and broadcasting of visual images.

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- 1.12 "Store and forward" is defined as a system that provides the ability to capture and store text, audio, static and video images and forward them for the review and opinion of a physician.
- 1.13 "Rotation Duty" means scheduled hospital emergency department duty providing on-site emergency department physician coverage or physicians providing first call coverage for an emergency department with greater than 25,000 visits per year.
- 1.14 Unless otherwise stated, the term "encounter" used in this Schedule means each separate and distinct time a physician provides services to a patient in a given day as defined in GR 1.19. To be recorded as separate encounters, multiple services provided to a patient may not be initiated by the physician, 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 physician is requested to attend the patient by hospital or nursing home staff, additional encounters may be claimed.
- 1.15 "Conceptual age" is defined as the estimated gestational age from the actual time of conception. It is usually considered to be at least 14 days after the first day of the last menstrual period.
- 1.16 "Neonate" is defined as a newborn infant up to and including 30 days of age.
- 1.17 "Resident of Alberta" means a person lawfully entitled to be or to remain in Canada, who makes the person's home and is ordinarily present in Alberta and any other person deemed by the AHCIP regulations to be a resident, but does not include a tourist, transient or visitor to Alberta.
- 1.18 "Home visit" means a visit by a physician to provide care for a patient in their home.
- 1.19 "Day" means a period of 24 hours starting at midnight.
- 1.20 "Medical learner" means a supervised physician in training.
- 1.21 "HSC" means Health Service code.

2 APPLICATIONS

- 2.1 The benefits payable for services provided inside or outside Alberta by or under the supervision of a physician, shall be the benefit prescribed in the Schedule subject to GRs outlined herein.
- 2.2 Where a specific case contradicts a general statement within these GRs the specific shall override the general statement.
- 2.3 Claims for unlisted services will be assessed by comparing the service provided and the fee claimed with similar or comparable services listed in the Schedule. The assessment will be based on the time, complexity, and intensity of the services. Supporting information, such as an operative report, is required with the claim.

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2.4 SPECIALIST

- 2.4.1 Specialist benefit rates may be claimed only by a physician who has received a specialist certificate in accordance with the Medical Profession Act.
- 2.4.2 An interim certificate issued by the College of Physicians and Surgeons of Alberta will be accepted in lieu of a formal certificate where a physician has completed the requirements for a specialist certificate and is awaiting formal recognition.

2.5 CATEGORY CODES

- 2.5.1 All health service codes in this Schedule are assigned a category code as follows:
- C - Anaesthetic
 - R - Surgical Assist
 - V - Visit
 - T - Test
 - M - Minor Procedure
 - M+ - Designated Minor Procedure
 - PV - Pilot Project Visit
 - 1, 3, 4, 6, 14, 15 - Major Procedure

- 2.5.2 Unless otherwise specified in this Schedule, health service codes designated with a T category code may be claimed with visits and consultations on the same day.

2.6 Variations in Payments

Benefits may be claimed in excess of those listed in the Schedule for services involving unusual complications or care. Requests for increased compensation require additional documentation, either an operative report or other detailed description of the care to support the claim.

2.7 CLAIMS FOR BENEFITS

- 2.7.1 A claim must be submitted in the format prescribed by the Minister.
- 2.7.2 GR 2.7.1 applies whether the claim is submitted by a physician on behalf of a patient or by the patient.
- 2.7.3 For administrative purposes the start of the day is considered to be midnight. A hospital visit which takes place after 0700 hours may be claimed in addition to one of the following services provided between midnight and 0700 hours:
- a) emergency home visit and admission to a hospital and hospital visit on the same day;
 - b) home visit;
 - c) hospital admission or consultation claimed in lieu of hospital admission;
 - d) emergency visit/special callback to hospital emergency/outpatient department, when specially called from home or office;
 - e) a special call for attendance to a patient at a closed office, with no staff in attendance.
- 2.7.4 Unless the Minister considers that extenuating circumstances exist:

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- a) a claim for benefits is not payable if it is submitted more than 180 days after the date:
 - i) on which the health service is provided; or
 - ii) the patient is discharged from hospital.
- b) a resubmitted claim for benefits is not payable unless it is resubmitted within 180 days from the date of the last Statement of Assessment on which that claim appeared.

2.7.5 Claims may be submitted by a physician who is present and supervising a resident or intern during the provision of a service.

3 EXCLUSIONS

3.1 The following includes examples of, but is not limited to, services which are not a benefit under the Schedule and may not be claimed:

- a) Advice by telephone or other telecommunication methods except as specified under specific health service codes or for telehealth services;
- b) Ambulance services, except ambulance detention time 13.99K;
- c) Anaesthetic materials;
- d) Any service a physician provides to a member of his/her own family;
- e) Drugs/agents;
- f) Intravenous sedation for dental procedures administered to a patient who is not an inpatient or registered outpatient of a hospital;
- g) Medical appliances;
- h) Medical testimony in court, except psychiatric opinion at psychiatric review panel under the Mental Health Act;
- i) Secretarial or reporting fees;
- j) Stand-by time;
- k) Travel time of a practitioner to see a patient;
- l) Services requested or required by a third party. Examples include but are not limited to:
 - Examinations or certification related to adoption;
 - Medical examinations to indicate fitness to attend camp;
 - Autopsies;
 - Employment examinations and reports;
 - Examinations and reports requested under the auspices of the Child Welfare Act;
 - Immigration requirements;
 - Insurance/disability reports and forms;
 - Examinations and reports for judicial purposes (e.g., requested by police);
 - Medical-legal reports requested by patients or by lawyers on behalf of patients;
 - Motor vehicle license (except after age 74.5 years);
 - Examinations and forms relating to participation in sports;
 - Examinations and forms relating to university or other school requirements;
 - Passport and visa applications.

3.2 Benefits may not be claimed by a surgeon, surgical assistant or anaesthetist with respect to:

- a) a procedure performed for cosmetic reasons;
- b) 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.

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Supporting documentation reflecting the need for the change must be retained by the physician.

- 3.3 Except for services known to be uninsured, the initial visit(s) to establish a diagnosis of the patient's condition is an insured service, including situations where the patient has been referred to another physician. After establishing a diagnosis during the initial visit(s), if the physician determines the service is not medically required, or is an uninsured service, all subsequent services related to the uninsured service such as preoperative tests, assessments, consultations, surgical procedures, anesthetic or surgical assists may not be claimed.
- 3.4 Uninsured services may not be claimed. Examples of uninsured services include but are not limited to:
- Services, including procedures, which are not medically required;
 - Acupuncture;
 - Artificial insemination;
 - Chelation therapy which is not provided to a hospital inpatient for the purpose of treating lead poisoning;
 - Eye surgery intended for the sole purpose of eliminating the need for eyeglasses or contact lenses;
 - Gamete intrafallopian transfer;
 - In vitro fertilization;
 - Ovarian stimulation and monitoring in association with assisted reproductive technologies;
 - Sperm transfer;
 - Cosmetic liposuction;
 - Breast enlargement for purposes other than specifically listed in the schedule;
 - Oculo-visual examinations for residents aged 19 through 64 years.

3.5 Deleted

3.6 Deleted

3.7 Deleted

4 VISITS AND CONSULTATIONS

4.1 COMPLETE EXAMINATION - DEFINITION:

In the context of GR 4, complete physical examination shall include examination of each organ system of the body, except in psychiatry, dermatology and the surgical specialties. "Complete physical examination" shall encompass all those organ systems which customarily and usually are the standard complete examination prevailing within the practice of the respective specialty. What is customary and usual may be judged by peer review.

4.2 VISITS - DEFINITIONS

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

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- 4.2.2 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.
- 4.2.3 Comprehensive Visit: An in-depth evaluation of a patient. This service includes the recording of a complete history and performing a complete physical examination appropriate to the physician's specialty, an appropriate record and advice to the patient. It may include the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient.
- 4.2.4 Palliative Care: Defined as care given to a patient with a terminal disease such as cancer, AIDS or advanced neurologic disease. Palliative care involves active ongoing multi-disciplinary team care. Physicians involved in palliative care may claim for services provided under 03.05I, 03.05T and 03.05U as applicable.
- 4.2.5 Chronic Pain: Defined as pain which persists past the normal time of healing, is associated with protracted illness or is a severe symptom of a recurring condition.
- a) Chronic Pain Program: Defined as a comprehensive, coordinated, interdisciplinary management program for persons complaining of chronic pain. The interdisciplinary team consists of a medical director; other team members will include anaesthetist(s), psychologist(s) and/or psychiatrist(s) and physiotherapist(s) and/or occupational therapist(s) and may include other professional personnel.
- 4.2.6 Telephone or Telecommunications Advice to Alberta home care or community mental health care workers: Defined as advice provided in relation to the care and treatment of a patient receiving Alberta home care or community mental health care services.
- 4.2.7 Comprehensive Visit in Emergency Department: An in-depth evaluation of a patient with a new or existing medical condition, including the recording of a complete history and a complete physical examination, and, where required, the ordering and reviewing of laboratory tests and x-rays and the initiation of appropriate therapy. May also be claimed for those patients whose illness or injury requires prolonged observation, continuous therapy and/or multiple reassessment(s). May be claimed by emergency medicine physicians, full-time emergency room physicians, general practitioners and pediatricians working a rotation duty shift in an emergency department with 24 hour on-site physician coverage.
- 4.2.8 Deleted
- 4.3 CONSULTATIONS - DEFINITIONS
- 4.3.1 Comprehensive Consultation: An in-depth evaluation of a patient with a written report to the referring physician, Alberta registered midwife, podiatrist, dentist, optometrist or nurse practitioner. This service includes the recording of a complete history, performing a complete physical examination appropriate to the physician's specialty, an appropriate record and advice to the patient. It may include the ordering of appropriate diagnostic tests and procedures as well as discussion

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with the patient and/or the referring physician, midwife, podiatrist, dentist, optometrist or nurse practitioner.

4.3.2 Limited Consultation: Limited assessment of a patient and a written report to the referring physician, Alberta registered midwife, podiatrist, dentist, optometrist or nurse practitioner. 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/or the referring physician, midwife, podiatrist, dentist, optometrist or nurse practitioner.

4.3.3 Time Based Consultations: Notwithstanding GRs 4.3.1 and 4.3.2, claims for consultation services as defined under health service codes 03.08F, 03.08G, 03.08I, 03.08J, 03.08L, 08.19A, 08.19AA, 08.19B, 08.19BB, 08.19C, and 08.19CC may be claimed on a time basis.

4.3.4 Psychiatric Consultation referred by other professions: A benefit for a psychiatric consultation (08.19AA, 08.19BB, 08.19CC) may be claimed when a patient is referred to a psychiatrist by an occupational therapist, psychologist, social worker or speech language pathologist and the provisions that apply to consultations under GRs 4.3, 4.4 and 4.6 are met.

Claims for these health service codes must be submitted with the name and discipline of the referring practitioner.

4.4 CONSULTATION - APPLICATION

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

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

- a) some unusual or serious clinical problem,
- b) a physician, midwife, podiatrist, dentist, optometrist or nurse practitioner requires further advice regarding diagnosis or management, or both, or
- c) the patient, parent or guardian requests another opinion.

4.4.3 A referral may be accepted from any person; however, to receive reimbursement as a consultation, a request must be made by the referring physician, midwife, podiatrist, dentist, optometrist or nurse practitioner to the consultant in the form of:

- a) verbal or written communication (fax, email, letter);
- b) verbal or written communication between an agent representing the referring physician, midwife, podiatrist, dentist, optometrist or nurse practitioner and the consultant;
- c) verbal or written communication between the referring physician, midwife, podiatrist, dentist, optometrist, or nurse practitioner and an agent representing the consultant;

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- d) verbal or written communication between agents representing the referring physician, midwife, podiatrist, dentist, optometrist or nurse practitioner and the consultant.

Agent means any of the following individuals who are acting under the direction of the referring physician, midwife, podiatrist, dentist, optometrist or nurse practitioner and the consultant, as appropriate:

- a) an employee of a physician, midwife, podiatrist, dentist, optometrist or nurse practitioner; or
- b) a hospital or long term care facility staff member; or
- c) a supervised physician in training acting under the direction of a physician.

Payment for a consultation to an Alberta physician may also be made when an Out of Province physician refers the patient and the criteria stated herein are met.

- 4.4.4 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.
- 4.4.5 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 physician, midwife, podiatrist, dentist, optometrist or nurse practitioner.
- 4.4.6 Repeat consultations may not be claimed unless a further request has been initiated by and received from the referring physician, midwife, podiatrist, dentist, optometrist or nurse practitioner for another consultation. A repeat consultation may not be claimed if initiated by the consultant.
- 4.4.7 When a physician sends a member of his family to another physician, a consultation benefit may not be claimed.
- 4.4.8 CLAIMS REQUIRING REFERRING PRACTITIONER NUMBER

When a claim is submitted for the following HSCs, the referring practitioner field must be completed with a valid referring practitioner number.

HSCs in the following list marked with an asterisk(*) cannot be self-referred. Self-referred means the physician is providing the diagnostic service and treating the patient.

HSCs in Section E (Lab and Pathology) and X (Diagnostic Radiology) require a valid referring practitioner number with the following exceptions:
 HSC X27D does not require a referral and HSC X27F may be self-referred.
 HSC 03.03D requires a valid referring physician number when it is a visit to a referred patient.

01.01A	01.03	01.04A	01.05A	01.09	01.12
01.12A	01.14	01.16A	01.22	01.24A	01.24B
01.32	01.34	02.82A	02.84A	02.84B	
03.03D	*03.03F	*03.03FA	*03.03G	*03.05B	*03.07A
*03.07B	*03.07C	*03.08A	*03.08B	*03.08C	*03.08F

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*03.08G	*03.08H	*03.08I	*03.08J	*03.08K	*03.08L
*03.09A	*03.09B	03.12A	03.16A	03.16B	03.16C
03.16D	03.19A	03.19B	03.19C	03.19D	03.21A
03.22A	03.22B	03.25	03.26	03.29A	03.37A
03.37B	03.38A	03.38B	03.38C	03.38D	03.38E
03.38F	03.38G	03.38H	03.38J	03.38K	03.38L
03.38M	03.38N	03.38P	03.38R	03.38S	03.38T
03.38U	03.38V	03.38W	03.41A	03.41B	03.41C
03.41D	03.52A	03.52B	03.52C	03.52D	03.55A
03.55B	03.56A	03.56B	03.58A		
06.35A	06.35B	06.39A	06.39B	07.09A	07.09B
*08.19A	*08.19B	*08.19C	*08.19AA	*08.19BB	*08.19CC
09.01A	09.01B	09.01C	09.01E	09.02B	09.05A
09.05B	09.06A	09.07A	09.07B	09.11A	09.11B
09.11C	09.12A	09.13A	09.16A	09.21A	09.21B
09.22A	09.22B	09.23A	09.23B	09.24A	09.24B
09.26A	09.26B	09.26C	09.26D	09.41A	09.41B
09.43A	09.43B	09.43C	09.43D	09.43E	09.46A
09.49A					
10.04	10.08A	10.33B	13.99CC	*13.99G	14.49A
14.82	14.84	14.85A	14.85B	14.88A	14.88B
15.94A	16.83A	16.83B	16.83C	16.89A	16.92B
17.31A	17.32B	17.81B	19.81		
22.81	24.81	24.89A	24.89B	28.8 A	28.81
29.0 A	29.81	30.81A	33.22B	33.89A	37.81
37.82A	37.82B	38.89A	38.89B	39.21A	39.62A
39.83A					
40.92A	41.29A	41.29B	42.09B	43.81	43.82
44.3 B	45.81A	45.83	45.84B	45.86A	46.5 A
46.81A	46.82	46.84A	46.88A	47.42A	48.92A
48.98A	48.98B	49.93A	49.95A	49.96A	49.96B
49.98A	49.98B	49.98C	49.98D		
50.81A	50.81B	50.81C	50.81D	50.81E	50.82A
50.82B	50.83A	50.84A	50.84B	50.84C	50.87A
50.87B	50.87C	50.88A	50.89A	50.89B	50.89C
50.89D	50.89E	50.91A	50.91B	50.94A	50.95A
50.95B	50.98A	52.1 A	52.11A	52.12	52.13
52.85A	53.81A	53.81B	53.83A	54.21A	54.89A
54.89B	54.89D	54.89E	54.89F	57.92A	
60.82C	60.89A	61.04	62.12A	62.12B	62.81A
63.86A	63.96B	64.95A	64.97A	66.19A	66.3 C
66.83	66.89A	66.89B	66.89C	67.01A	67.01B
67.01C	67.81	67.86	67.87A	67.89A	68.95
69.83A	69.83B	72.91	72.92A	74.82A	75.83A
76.89A	78.7 A	79.29E			
80.81	80.83B	80.85A	80.85B	82.12A	82.81A
82.91A	83.7 A	87.4	87.53A	87.53B	87.54A
87.55A	89.59A	89.59B	89.59G	89.98A	92.70
92.71	92.72	92.74	92.75	92.76	92.78A

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92.78B	92.78C	92.8 A	92.8 B	95.81A	97.11A
97.11B	97.81	97.82A	97.83A	97.89A	97.89B
98.12A	98.12B	98.12Q	98.8 A	98.81A	98.81B
98.89A	98.89B	98.89C	98.89D	98.89E	98.89F
98.89G	98.89H				

F7	F8	F9
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4.5 CONSULTATION: PHYSICIANS ON ROTATION IN THE EMERGENCY DEPARTMENT

4.5.1 A physician on rotation duty in the emergency department may claim a comprehensive consultation when the conditions in GR 4.3 have been met.

- a) Deleted
- b) Deleted

4.5.2 A limited consultation may be claimed when dealing with one particular problem and shall include interpretation of laboratory tests, and a written report to the referring physician, midwife, podiatrist, dentist, optometrist, or nurse practitioner who must care for the patient in the future. A claim for a limited consultation may be made when there is a written request or other documented communication from the referring physician, midwife, podiatrist, dentist, optometrist, nurse practitioner or their agent for an opinion or treatment by the emergency physician.

4.6 LIMITATION ON VISITS AND CONSULTATION DESCRIBED AS COMPREHENSIVE

4.6.1 Comprehensive visits and/or comprehensive/major consultations may only be claimed once every 180 days per patient by the same physician. Comprehensive visit and consultation services are defined as HSCs 03.04A, 03.08 series, 03.09B, 08.11A, 08.19A and 08.19AA. There must be an interval of 180 days between the first and second comprehensive services.

4.6.2 Notwithstanding GR 4.6.1, 03.08A may only be claimed for patients under 12 months of age once every 90 days per patient by the same physician. There must be an interval of 90 days between the first and second consultation.

4.6.3 Notwithstanding GR 4.6.1, an initial prenatal examination 03.04B may not be claimed within 90 days of another comprehensive visit or consultation. Comprehensive visit and consultation services are defined under GR 4.6.1. There must be an interval of 90 days between the first and second services.

4.7 OTHER LIMITATIONS ON VISIT ITEMS

In general, when an office visit and a hospital admission are provided to a patient on the same day by the same physician, only the greater benefit may be claimed. There are two exceptions to this. Firstly, if a new condition arose and the patient was seen at two separate encounters, both services may be claimed. Information must accompany this claim. Secondly, two services may be claimed when they fall within the provisions of GR 2.7.3.

4.8 CONCURRENT CARE IN HOSPITAL

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4.8.1 If the services of more than one physician are required because of the complexity of the clinical needs of a patient, each physician may claim a benefit for concurrent care. Satisfactory supporting information must accompany the claim.

4.8.2 If a consultation is required, the attending physician and the consultant may each claim for services provided on the day of consultation.

4.8.3 If the provisions of GR 4.4.5 apply, a benefit may be claimed by the referring physician only after the full responsibility for the care of the patient has been returned to him/her, or the complexity of the clinical needs of the patient require the services of the referring physician in addition to those of the consultant.

4.8.4 When the care of the patient remains with the referring physician, midwife, podiatrist, dentist or nurse practitioner and the nature of the illness makes further intermittent visits by the consultant advisable, they may not be claimed as repeat consultations.

4.9 SUPPORTIVE CARE

4.9.1 When a patient is in hospital under a specialist's care, and the family physician or paediatrician is not actively managing the case, the family physician or paediatrician may claim supportive care benefits (03.05M, 03.05MA). The following criteria apply:

- a) deleted
- b) the patient, the patient's family or the most responsible physician specifically requests that the family physician or paediatrician visit for the purposes of liaison or reassurance.

4.9.2 If medical complications develop or are present which require active management by the family physician, hospital visits should be claimed in accordance with GR 4.8.

4.10 TRANSFER OF CARE

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

4.10.2 If a physician transfers the care of a hospitalized patient to a second physician, the second physician may claim daily care. The applicable benefit rate will be determined by the number of days of the patient's hospitalization except as provided in GR 4.10.3.

4.10.3 When the care of a patient is transferred to a second physician, the second physician may charge daily hospital care, starting at the rate allowed for the first to seventh day, only if the transfer was due to the onset of a significant new illness.

4.10.4 If a patient is transferred to another hospital under the care of another physician, hospital visit services shall be claimed as though this were a first admission.

4.10.5 A physician who admits a patient to hospital and provides pre-operative care but does not perform the surgery, may claim benefits for the services up to and including the day of surgery.

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4.11 PSYCHOTHERAPY

- 4.11.1 A physician may submit claims for group psychotherapy, psychiatric management and/or indirect services for the same patient on the same day.
- 4.11.2 Psychotherapy or psychiatric management claims for time units may be submitted for separate encounters for the same patient on the same day.
- 4.11.3 Deleted

4.12 NEWBORN AND PREMATURE CARE - PAEDIATRIC SPECIALIST

- 4.12.1 The benefit for care of a healthy newborn in hospital does not apply when the infant is ill. In these circumstances, the daily hospital visit items apply.
- 4.12.2 If newborn and premature care is provided by a paediatrician,
 - a) item 03.05G may be claimed for care of a healthy newborn infant referred by anyone practising obstetrics and in this instance no consultation benefit may be claimed;
 - b) if an infant appears initially well but becomes ill after a number of days and consultation is required as well as continuing daily care, benefits may be claimed for consultation under item 03.08A and for the appropriate number of hospital days involved;
 - c) if consultation is requested during the newborn period and continuing care is not required, a consultation benefit may be claimed, but not item 03.05G, and
 - d) subject to 4.12.1 routine care of a premature infant may be claimed as item 03.07A for the initial visit and continuing daily care benefits may be claimed as item 03.03D.
- 4.12.3 Routine care is considered to include minor conditions.
- 4.12.4 Routine follow-up visits provided for a premature infant after 90 days and 180 days of age may each be claimed under item 03.03A.

4.13 NEWBORN AND PREMATURE CARE - OTHER THAN PAEDIATRICIANS

- 4.13.1 The benefit for care of a healthy newborn in hospital does not apply when the infant is ill. In these circumstances, the daily hospital visit items apply.
- 4.13.2 If a physician performs the delivery and resuscitates the infant, item 13.99F may be claimed in addition to a delivery benefit.
- 4.13.3 The benefit for care of a healthy newborn in hospital may be claimed by the same physician who claimed the benefit for the delivery.
- 4.13.4 If newborn and premature care is provided by a physician other than a paediatrician,
 - a) the benefit for care of a healthy newborn may be claimed under item 03.05G whether or not the case is received as a referral;
 - b) if a consultation is required, a claim under item 03.05G may be claimed by the attending physician and a consultation benefit by the consultant;

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- c) if a newborn requires transfer to a consultant, a benefit to the attending physician may be claimed on a fee for service basis, and
- d) subject to 4.13.5 routine care of a healthy premature newborn may be claimed as applicable visit items.

4.13.5 Routine care is considered to include minor conditions.

4.13.6 Routine follow-up visits provided for a premature infant after 90 days and 180 days of age may each be claimed under item 03.03A or its equivalent.

4.14 POST PARTUM OFFICE VISITS

Whether the baby is ill or well the first office visit of a newborn, within 14 days of the date of birth, cannot exceed the "limited" evaluation rate if the physician has received payment for care of healthy newborn in hospital (03.05G) or inpatient care.

Subsequent to the initial post-partum visit, a physician may charge under whatever health service codes are appropriate for the care provided.

4.15 PRONOUNCEMENT OF DEATH

When a physician is specially called and attends on a priority basis to pronounce a death, a visit benefit may be claimed. There is no additional benefit for completion of a death certificate.

5 EMERGENCY/CRITICAL CARE

5.1 EMERGENCY DEPARTMENT VISITS/ASSESSMENTS BY ROTATION DUTY PHYSICIANS OR BY PHYSICIANS PROVIDING FIRST CALL COVERAGE IN AN EMERGENCY DEPARTMENT THAT HAS GREATER THAN 25,000 VISITS TO THE EMERGENCY ROOM PER YEAR

5.1.1 Health service codes 03.05CR, 03.05DR, 03.05ER and 03.05F may only be claimed by physicians on rotation duty or by physicians who are providing first call coverage in an emergency department that has greater than 25,000 visits to the emergency room per year.

5.1.2 Only one of health service codes 03.05CR, 03.05DR or 03.05ER may be claimed by either the same or a different physician, on the same date of service when the patient has remained in the emergency department.

5.1.3 Deleted

5.1.4 When the patient has been discharged from the emergency department and returns on the same day, another visit by the same or different physician may be claimed.

5.1.5 Health service code 13.99H may not be claimed in association with another visit health service code. Time units may be claimed on a cumulative basis.

5.1.6 If a physician on rotation duty in a hospital emergency department or a physician who is providing first call coverage in an emergency department that has greater than 25,000 visits to the emergency room per year and a second physician submit claims for visits to the same patient on the same day, the following rules apply:

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- a) If the patient is not admitted, the physician on rotation duty or the physician who is providing first call coverage in an emergency department that has greater than 25,000 visits to the emergency room per year may be paid and the second physician may only be paid when specially called to attend that specific patient.
- b) If the patient is admitted, both physicians may be paid and in this case, the second physician does not have to be specially called to claim for inpatient services.

5.2 SPECIAL CALLBACKS TO HOSPITAL EMERGENCY/OUT-PATIENT DEPARTMENT BY
NON-ROTATION DUTY PHYSICIANS

- 5.2.1 Health service codes 03.03K, 03.03L, 03.03MA and 03.03MB may be claimed when a physician is especially called from home or office to a hospital emergency department to attend one patient. Maximums apply, see GR 15.11.
- 5.2.2 If a physician is in a hospital for any purpose and is asked to see a patient in the emergency department, health service codes 03.03K, 03.03L, 03.03MA, 03.03MB do not apply. Benefits may be claimed for the applicable visit or procedure.
- 5.2.3 Services provided to additional patients seen during the same callback, or services over the limits specified in GR 15.11 may be claimed as:
 - a) 03.05CN, 03.05DN and 03.05EN according to the time of day,
 - b) 03.02A, 03.03A, 03.03Z, 03.04A as appropriate, or
 - c) the applicable procedure.

5.3 BENEFITS FOR INTENSIVE CARE SERVICES (ICU).

- 5.3.1 Services provided to patients on a ventilator are eligible for an additional benefit; refer to HSC 13.62A.
- 5.3.2 Benefits for unscheduled services may be claimed according to GR 15.
- 5.3.3 Deleted
- 5.3.4 Deleted
- 5.3.5 Deleted
- 5.3.6 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.

5.4 Deleted

- 5.4.1 Deleted
- 5.4.2 Deleted
- 5.4.3 Deleted
- 5.4.4 Deleted

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5.5 Deleted

5.5.1 Deleted

5.5.2 Deleted

5.5.3 Deleted

- a) Deleted
- b) Deleted
- c) Deleted

5.5.4 Deleted

5.5.5 Deleted

5.6 Deleted

5.6.1 Deleted

5.6.2 Deleted

- a) Deleted
- b) Deleted

5.6.3 Deleted

- a) Deleted
- b) Deleted
- c) Deleted
- d) Deleted
- e) Deleted
- f) Deleted

5.6.4 Deleted

5.6.5 Deleted

5.6.6 Deleted

5.6.7 Deleted

6 PROCEDURES

6.1 If a physician performs a minor 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 minor procedure 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 physician who placed sutures may not claim for removing them. A second physician who is in the same practice group as the surgeon may not claim for removing the sutures either. However, a second physician may claim a visit for removal of sutures if he is not a member of the same practice group as the practitioner who put the sutures in.

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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 inpatient or registered outpatient 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 physician'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 GR 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 physician's office, either a procedural benefit or a visit benefit, but not both, may be claimed for that day. A consultation benefit pursuant to GR 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.
- 6.7.3 Deleted

6.8 MAJOR PROCEDURES

- 6.8.1 Health service codes with a designated category code of 1 and 15 include related post-operative services and those with a designated category code of 3, 4, 6 and 14 include both related pre-operative and post-operative services.
- The following are exceptions:
- a) a consultation benefit may be claimed up to and including the day of surgery.
 - b) pre-operative hospital care may be claimed by the physician who performs the surgery if information is submitted to show that conservative treatment was attempted before surgery was performed.

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- c) benefits may be claimed as applicable for complications occurring during or following post-operative time periods.
- d) Deleted

The following chart gives the pre-operative and post-operative periods.

Category	Pre-operative	Post-operative
1	0 - Days	14 - Days
3	7 - Days	7 - Days
4	7 - Days	14 - Days
6	14 - Days	14 - Days
14	30 - Days	14 - Days
15	0 - Days	7 - Days

6.8.2 Deleted

6.8.3 Deleted

- a) Deleted
- b) Deleted

6.8.4 Where a procedure is performed under general anaesthesia, the following applies:

- a) If the procedure is the only procedure performed at that time, a benefit of \$125.90 may be claimed.
- b) If another procedure is also performed at the same encounter and the listed benefit payable in respect of it under the Schedule is greater than \$125.90 the physician is entitled to receive that listed benefit plus a percentage of the listed benefit for the lesser procedure(s) calculated in accordance with this Schedule. The \$125.90 minimum benefit does not apply to the lesser procedures.
- c) If multiple procedures are performed at the same encounter and the listed benefit payable in respect of each of them under the Schedule is less than \$125.90, the physician is entitled to receive a benefit of \$125.90 in respect of the greater procedure plus a benefit in respect of each of the lesser procedures that is a percentage of the listed benefit and calculated in accordance with this schedule. The \$125.90 minimum benefit does not apply to the lesser procedures.
- d) If multiple procedures are performed at the same encounter and only one of them appears under GR 6.8.4 (e), the physician is entitled to receive a benefit of \$125.90 in respect of that procedure plus a benefit in respect of the other procedures that is a percentage of the listed benefit and calculated in accordance with this schedule.
- e) GR 6.8.4 applies to the following HSCs:

01.01A	01.03	01.09	01.24A	01.24B	02.84B
03.22A	03.22B	03.25	07.29A	07.51B	07.57A
10.23	10.25	11.81A	12.01	12.21	12.24
12.31	13.59K	13.99BB	14.09A	17.39E	17.81A
19.81					
21.0 A	21.31A	21.32A	21.41	21.42	21.69A
21.83	22.11A	22.13B	22.5 A	22.81	24.22A
24.5	24.81	25.1 A	26.91A	27.7 E	28.8 A
30.19A	30.19B	30.9 A	32.01A	32.1	32.21A
32.23A	32.39A	33.22A	33.22B	33.51A	33.51B
33.61A	34.0 A	34.1 A	34.89A	35.0 A	37.81

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37.82A	38.0 A	38.89A	39.21A	39.62A	39.83A
40.5	40.92A	43.95A	45.81A	45.83	45.84A
46.04B	46.84A	49.0	49.82B	49.83A	50.4 A
50.94A	50.97A	51.43	51.53A	52.0 A	52.1 A
53.81B	53.83A	54.92D			
60.24A	60.82C	61.01A	61.04	61.29A	61.37A
61.39A	61.4 B	62.81A	64.95A	67.81	67.86
67.96A	68.1	68.32B	69.13D	69.29A	69.83A
69.83B	70.1	70.2 A	70.2 B	70.2 H	70.4 F
70.5 A	72.91	74.82A	76.91A	78.7 A	79.29E
80.81	80.83B	80.85B	81.8	81.96	82.0 A
82.12A	82.12B	82.12C	82.14D	82.63	82.81A
82.91A	83.09A	83.19A	83.2 B	83.61	83.7 A
87.6	87.72A	87.82	87.89A	87.89B	87.91
87.92	88.92	89.59A			
91.01H	91.01J	91.02A	91.03A	91.03B	91.05E
91.05H	91.06D	91.06E	91.07A	91.08B	91.12A
91.13A	91.13B	91.70A	91.70B	91.71	91.73A
91.73B	91.77B	91.77C	91.78A	91.78B	92.13
93.91A	93.91B	94.04	94.85	95.02A	95.03
95.81A	95.93	95.96A	96.01A		
97.81	97.96	98.03A	98.04A	98.12A	98.12B
98.12C	98.12E	98.12H	98.12J	98.12K	98.12M
98.12N	98.12Q	98.12R	98.22A	98.49A	98.6 A
98.6 C	98.81A	98.92A	98.92B	98.93A	98.93B
98.96A	98.96B	98.96C	98.96D	98.98B	

6.8.5 GR 6.8.4 does not apply to surgical assistance or anaesthetic benefits.

6.8.6 If a surgeon 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.

6.8.7 The physician providing the post-operative care under GR 6.8.6 may submit claims on a fee for service basis.

6.8.8 For those unusual situations where surgery is performed by a travelling surgeon (in accordance with the policy of the College of Physicians and Surgeons of Alberta) the full benefit for the procedure may be claimed. If another physician participates in post-operative care his/her services may be claimed 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 surgeon through separate incisions under one anaesthetic, the claim for the lesser procedure may be claimed at 75% of the listed benefit.

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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 physicians 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 physician, a benefit may be claimed for the major procedure only.

6.9.6 If multiple unrelated abdominal procedures are performed through one incision, by more than one physician, the benefit for the major procedure may be claimed in full by the physician most responsible for the patient's care and at 75% by the other physician, irrespective of the value of either procedure.

6.9.7 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,
- e) a procedure listed in the following table which may be claimed at 100% when performed as a second or subsequent procedure by any physician, regardless of whether the procedures are performed by one or more physicians and regardless of whether additional incisions are required to perform the procedure. This does not apply to anesthetic services; refer to GR 12.4.9.

16.09N	16.09O	16.09P	16.3 A	16.3 B	16.43D
16.43E	16.49B	16.49C	16.49D	16.49E	16.49F
16.49G	17.08A	17.39C	17.5 D		
89.09A	89.12A	89.12B	89.19A	89.20A	89.21
89.22A	89.22B	89.24	89.26A	89.33A	89.36A
89.36C	89.37A	89.37B	89.38B	89.38C	89.38D
89.38E	89.38F	89.38G	89.41A	89.41B	89.42A
89.59F	89.59G	89.6 A	89.78D	89.78H	89.78I
89.78J	89.78K	89.78L	89.78M	89.78N	89.78P
89.78Q	89.78R	89.78S	89.78T	89.78U	89.78V
89.78W	89.78X	89.78Y	89.85	89.88A	
90.00A	90.01	90.02B	90.02C	90.03A	90.03C
90.04	90.05A	90.06A	90.06B	90.07A	90.07B
90.09A	90.09B	90.09C	90.2 A	90.32A	90.32B
90.34A	90.34B	90.39A	90.5 A	90.5 B	90.6 D
90.6 E	90.6 F	91.00B	91.00E	91.01E	91.01G
91.04E	91.05K	91.06C	91.08G	91.08L	91.09A
91.10A	91.14A	91.14B	91.14C	91.15A	91.15B
91.22A	91.22B	91.30A	91.30B	91.30C	91.30D
91.30F	91.30G	91.30H	91.30I	91.31B	91.31C
91.31D	91.31E	91.31F	91.31G	91.31H	91.31J
91.32B	91.32C	91.33B	91.34A	91.34B	91.34C

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91.34D	91.34E	91.34F	91.34G	91.34H	91.35A
91.35B	91.35C	91.35D	91.35G	91.35H	91.35K
91.35L	91.35M	91.35N	91.36A	91.36B	91.36C
91.36D	91.36E	91.36F	91.36G	91.37A	91.38A
91.38D	91.38F	91.38H	91.38J	91.38K	91.44B
91.74B	91.80				
91.80A	91.81	91.82A	91.84A	91.84C	91.84D
91.85A	91.86	91.87A	91.87B	91.88A	91.88B
91.90A	92.10	92.11	92.14	92.31C	92.31D
92.31E	92.31F	92.31H	92.31J	92.31K	92.31L
92.31M	92.31N	92.31P	92.31Q	92.31R	92.31S
92.32B	92.32C	92.32D	92.40	92.41	92.44
92.45	92.46	92.8 A	92.8 B	92.8 C	92.8 D
93.01A	93.01B	93.02A	93.02B	93.05D	93.05E
93.06A	93.09B	93.09C	93.09D	93.09E	93.09F
93.09G	93.09H	93.11A	93.12A		
93.12B	93.12C	93.14	93.16A	93.18A	93.18B
93.21	93.22	93.23	93.24	93.25	93.26A
93.39B	93.39C	93.41A	93.44A	93.45A	93.45B
93.45C	93.45D	93.45E	93.45F	93.45G	93.45H
93.45J	93.45K	93.47A	93.47C	93.49A	93.49B
93.49C	93.59A	93.6 A	93.6 B	93.69A	93.69B
93.69C	93.71A	93.71D	93.8 A	93.81A	93.81B
93.83B	93.83C	93.83D	93.83E	93.83F	93.83G
93.83H	93.83I	93.83N	93.83O	93.84A	93.85A
93.87A	93.87E	93.87H	93.87J	93.87K	93.96B
93.96C	93.96D				
93.96E	93.96F	93.96G	93.96H	93.96I	93.96J
93.96K	94.01B	94.35A			
95.01B	95.12	95.13A	95.13B	95.14E	95.15A
95.15B	95.15C	95.15F	95.15G	95.19A	95.29A
95.32B	95.4 A	95.4 B	95.54A	95.54B	95.54D
95.54E	95.54F	95.54G	95.65B	95.65C	95.65D
95.65E	95.65F	95.66B	95.71B	95.75A	95.75B
95.76A	95.76B	95.76C	95.77A	95.78A	95.78B
95.78C	95.91C	95.99A	96.05	96.06	96.07
96.08	96.11A	96.13	96.14	96.15	96.16
96.17					

f) a procedure listed in the following table that may be claimed at 100% when performed as a second or subsequent procedure through a different incision by any physician, regardless of whether the procedures are performed by one or more physicians. This does not apply to anesthetic services; refer to GR 12.4.

66.3 B	71.7 A	71.7 B	78.52C	78.99B	79.1 A
79.3 E	79.4 A	80.19A	80.19B	80.19C	80.19D
80.19E	80.81	80.83B	81.09	81.29B	81.29C
81.51A	81.99A	82.12A	82.12B	82.12C	82.12D

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82.3 A	82.3 B	82.41A	82.42A	82.51A	82.62A
82.63	82.69B	82.7 A	82.81A	82.91A	83.19A
83.4 A	83.4 B	83.5 A	83.61	83.69B	83.7 A
83.9 A					

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

6.9.9 Claims may not be submitted for incidental procedures.

6.10 BILATERAL SURGERY - TWO SURGEONS

With the exception of the health service codes listed under GR 6.9.7e, when two surgeons operate on two sides at the same time, the surgeon most responsible for the patient's care may claim 100% of the listed benefit for the procedure she/he performs and the second surgeon may claim 75% of the benefit for the procedure she/he performs.

6.11 FRACTURES AND DISLOCATIONS

6.11.1 For a compound fracture, closed or open reduction, 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 With the exception of facial fractures treated by closed reduction, multiple fractures, other than undisplaced fractures, may be claimed at the full benefit for each fracture treated by closed reduction, open reduction, continuous traction or extensive skeletal traction. This does not apply to anesthetic services; refer to GR 12.4.9.

6.11.4 Deleted

6.11.5 If an open operation is performed for the purpose of implanting an electrical stimulator, for conditions such as non-union of fractures, the appropriate item for open reduction of the fracture may be claimed.

6.11.6 With the exception of 90.09A, 90.09B and 90.09C, benefits for bone grafting or bone graft harvesting and fixation (90.00 through 90.08 series) may not be claimed in association with an open reduction of a fracture of the same bone.

6.11.7 Benefits for bone grafts include harvesting and fixation where indicated.

6.11.8 Osteotomy (all health service codes 89.2 and 89.3 series) may not be claimed in association with the following:

- a) bone grafting (all health service codes 90.00 to 90.08 series) when performed at the same encounter
- b) primary or revision arthroplasty when the osteotomy is of an adjacent bone.

In these cases, only the greater benefit may be paid.

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- 6.11.9 For open reduction and mini plate fixation of facial fractures, if a bone graft is required to fill a defect, 75% of health service code 98.79A may be claimed in addition to the benefit for the fracture.
- 6.11.10 For an open reduction of a periprosthetic fracture (a fracture involving bone around any prosthesis), of a long bone when no revision arthroplasty of the same long bone is performed, 150% of the benefit for open reduction and internal fixation of the bone involved may be claimed using modifier PROSTH.
- 6.11.11 Benefits for orthopedic services include the application of a cast when required and replacement of the cast within the 14 day post operative period.
- 6.12 FRACTURES AND DISLOCATIONS - ATTEMPTED REDUCTION
- 6.12.1 If a physician attempts a closed reduction of a fracture unsuccessfully and finds it necessary to transfer the care of the patient to another physician, the referring physician may claim up to 50% of the benefit listed for such fractures.
- 6.12.2 The listed benefit may be claimed by the physician receiving the transferred patient and providing the final reduction.
- 6.13 FRACTURES AND DISLOCATIONS - OPEN FOLLOWING CLOSED REDUCTION
- 6.13.1 If the same physician 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 physician performs an open reduction following an attempted closed reduction, under a different anaesthetic, benefits for both may be claimed.
- 6.13.3 An additional 50% of the listed benefit may be claimed by orthopaedic surgeons for open reduction of a fracture with demonstrated radiographic non-union at least 12 weeks from the date of the initial fracture (NUFRAC modifier).
- 6.14 SAME PHYSICIAN, SEVERAL FUNCTIONS
- 6.14.1 In relation to either a single surgical procedure or a series of procedures under the same anaesthetic, only the surgical or the anaesthetic benefit, whichever is the greater, may be claimed.
- 6.14.2 Notwithstanding GR 6.14.1, the same physician who claims HSC 87.98B may also claim a surgical assist for cesarean section on the same patient on the same day. The conditions indicated under HSC 87.98B must also be met.
- 6.14.3 Notwithstanding GR 6.14.1, in a rural location, a physician may claim both HSC 87.98B and an anaesthetic service on the same day when:
- he or she must call in another physician to complete the delivery and
 - he or she provides an anaesthetic service for the delivery and
 - the conditions indicated under HSC 87.98B have been met.

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- 6.14.4 A physician acting as both a surgical assistant and a surgeon for separate procedures under one anaesthetic may submit a claim for both services.
- 6.14.5 When complex orthopedic surgery requires the skills of two orthopedic surgeons, the second surgeon may submit a claim using modifier SSOS for his/her services when he/she has actively participated in the planning for and performance of the procedure. Only the second orthopedic 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 anesthetic time claimed for the procedure.

Claims for health service codes that do not list modifier SSOS in the Price List may be submitted with supporting information.

6.15 REDO CARDIAC, VASCULAR AND THORACIC SURGERY

- 6.15.1 With the exception of the health service codes specified under GR 6.15.4, the benefits that may be claimed for redo cardiac, vascular and thoracic surgery are as follows:
- a) 150% of the listed benefit if the procedure is performed entirely through a previous incision;
 - b) 125% if part of the procedure is performed through a previous incision.
- 6.15.2 Health service codes 46.03B, 47.92C, 50.75A and 51.98A are defined as having a reoperative component and therefore are not eligible for redo modifiers. Health service codes 51.61A and 51.61B are also not eligible for redo modifiers.
- 6.15.3 A claim for a redo modifier may not be submitted unless the patient has left the operating room and post anaesthetic recovery room.
- 6.15.4 Benefits that may be claimed for redos for one of the following health service codes vary depending on how many redos have been performed in the past, (whether partly or wholly), through that incision. The first redo may be claimed at 175% of the listed benefit, the second at 225%, the third at 275%, the fourth at 325%, and the fifth at 375%.

44.21	44.3 A	44.3 B	44.4 A	44.4 B	44.4 C
44.5 A	44.5 B	45.1 A	45.1 B	45.5 A	45.6 A
46.3 C	47.02A	47.04	47.12A	47.12B	47.13A
47.13B	47.13C	47.14A	47.14B	47.15A	47.15B
47.15C	47.23A	47.25A	47.25B	47.25C	47.25D
47.27A	47.29A	47.39A	47.54A	47.54B	47.55A
47.55B	47.55C	47.81	47.82	47.83A	47.83B
47.84A	47.91A	47.92A	47.92B	47.93A	47.93B
47.95A	48.12	48.12A	48.13	48.13A	48.14
48.14A	48.15A	48.15B	48.15C	48.15D	48.15E
48.15F	48.15G	48.15H	49.12	49.12B	49.2
49.31	49.39	49.39B	49.39C	49.4 B	49.5 A
49.61A	49.62A	49.62B	49.7 B	49.7 C	49.9 A
49.91					
50.04A	50.05A	50.14	50.24A	50.24B	50.34A
50.34B	50.34D	50.34K	50.34L	50.75B	50.75C

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51.21A 51.21B 51.3 C

6.15.5 In cases where multiple redos are performed at the same encounter through the previous incision, the lesser procedures will be paid at 75% of the redo modifier benefits.

6.16 An additional 50% of the listed benefit may be claimed for cardiovascular and thoracic surgery when performed on neonates (as defined under GR 1.16) and infants under 44 weeks of conceptual age (as defined under GR 1.15).

6.17 REDO ORTHOPEDIC SURGERY

6.17.1 An additional 50% of the listed benefit may be claimed by orthopedic surgeons for redo orthopedic surgery on or relating to the same joint or muscle structure on which the patient has previously had an orthopedic surgical intervention (modifier ORREDO). This modifier may be claimed for HSCs 89.41A, 89.41B, 89.42A, 92.32C, 93.09B, 93.11A, 93.12A, 93.12B, 93.12C, 93.14, 93.16A, 93.18A, 93.18B, 93.21, 93.22, 93.23, 93.25, 93.26, 93.26A, 93.27, 93.28, 93.44A, 93.45G, 93.47C, 93.49B, 93.83B, 93.83C, 93.83D, 93.83F and 93.83G.

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

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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 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.

8 OBSTETRICS AND GYNAECOLOGY

8.1 OBSTETRICS - GENERAL

8.1.1 Obstetrical care is divided into its components. An initial prenatal visit 03.04B includes a full history, examination, completion of the prenatal record and advice to the patient. Usual prenatal care includes a prenatal visit, follow-up visits which would generally occur at four-week intervals to 32 weeks, followed by visits every second week to 36 weeks, then weekly visits until delivery. Additional visit or procedure items may be claimed as required for complicated pregnancies.

8.1.2 Prenatal visits (health service code 03.03B), emergency, outpatient and inpatient hospital visits may be claimed up to the time of delivery, including the day of delivery; except in the situation where delivery occurs within 24 hours of admission, in which case neither a hospital admission (03.04C) nor a hospital visit (03.03D) may be claimed.

8.1.3 Deleted

8.1.4 The delivery benefit includes payment to the attending physician for procedures such as surgical induction, episiotomy, repair of episiotomy or non-extensive lacerations (first or second degree as defined below), and ordinary immediate care of the newborn.

First degree is defined as a superficial laceration of the vaginal mucosa or perineal body which does not require suturing.

Second degree is defined as a laceration involving the vaginal mucosa and/or perineal skin and deeper subcutaneous tissue and requiring suturing.

Third degree is defined as an extension of the laceration which involves any part of the capsule or anal sphincter muscle or deep vaginal sidewall laceration.

Fourth degree is defined as extensive including involvement of the rectal mucosa.

8.1.5 When a delivery occurs within 24 hours of admission, the delivery benefit includes the hospital admission (health service code 03.04C) or hospital visit (03.03D). Post-partum hospital visits, by the same or different physician, for the period of either one or two weeks after the delivery according to the category code, and ordinary immediate care of the newborn are also included. When there is a life threatening situation which requires neonatal resuscitation, health service code 13.99F may be claimed as well.

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Supporting information may be requested.

8.2 Deleted

8.2.1 Deleted

8.2.2 Deleted

- a) Deleted
- b) Deleted
- c) Deleted
- d) Deleted

8.3 GYNAECOLOGY

8.3.1 Deleted

8.3.2 If a gynaecological procedure results in sterilization, 78.99B may not be claimed in addition.

9 OPHTHALMOLOGY

9.1 CLAIMS FOR COMPLETE EYE EXAMINATIONS AND SPECIAL EXAMINATIONS

9.1.1 The following examinations are included in the complete examination (03.04A, 03.08A, 03.08H, 09.04) and may not be claimed in addition:

- Measurement of vision
- Refractive error
- Extra-ocular muscle balance
- 03.12A Intra-ocular pressure measurement
- 09.01A Biomicroscopy (slit lamp examination)
- Retinal examination

9.1.2 One technical service and one interpretive service from the following examinations may be claimed in addition to health service codes 03.04A, 03.08A and 09.04:

- 09.01B Gonioscopy
- 09.01C Orthoptic analysis, interpretation
- 09.01E Orthoptic analysis, technical (may include Hess screen)
- 09.02B Anterior chamber depth measurement
- 09.05A Visual fields, technical
- 09.05B Full threshold on automated equipment, interpretation
- 09.06A Color vision test, interpretation and technical
- 09.11A Specular microscopy, technical
- 09.11B Specular microscopy, interpretation
- 09.11C Potential acuity measurement or laser interferometry
- 09.12A Fluorescein angiography, interpretation
- 09.13A Optical coherence tomography, technical and interpretation
- 09.26A Provocative tests
- 09.26B Tonography, technical
- 09.26C Tonography, interpretation
- 09.26D Corneal pachymetry
- 21.31A Irrigation probing of nasolacrimal duct
- 21.32A Probing of lacrimal canaliculi
- 24.89B Diagnostic conjunctival scraping

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9.1.3 One technical service and one interpretive service from the following examinations may be claimed in addition to health service codes 03.02A, 03.03A, 03.07A and 03.07B:

- 03.12A Intraocular pressure measurement
- 09.01A Biomicroscopy (slit lamp examination)
- 09.01B Gonioscopy
- 09.01C Orthoptic analysis, interpretation
- 09.01E Orthoptic analysis, technical (may include Hess screen)
- 09.02B Anterior chamber depth measurement
- 09.05A Visual fields, technical
- 09.05B Full threshold on automated equipment, interpretation
- 09.06A Color vision test, interpretation and technical
- 09.11A Specular microscopy, technical
- 09.11B Specular microscopy, interpretation
- 09.11C Potential acuity measurement or laser interferometry
- 09.12A Fluorescein angiography, interpretation
- 09.13A Optical coherence tomography, technical and interpretation
- 09.26A Provocative tests
- 09.26B Tonography, technical
- 09.26C Tonography, interpretation
- 09.26D Corneal pachymetry
- 21.31A Irrigation probing of nasolacrimal duct
- 21.32A Probing of lacrimal canaliculi
- 24.89B Diagnostic conjunctival scraping

9.1.4 When done independently on a separate day or as a repeat, not more than one interpretation and one technical service from the list in GR 9.1.3 may be claimed.

9.1.5 Deleted

9.2 Deleted

9.2.1 Deleted

9.2.2 Deleted

10 DENTAL/ORAL SURGICAL RELATED SERVICES

10.1 The appropriate listed anaesthetic benefit or the number of time units for the procedure may be claimed when the oral surgical procedure is listed under the Schedule of Oral and Facial Surgery Benefits.

10.2 Dental anaesthetic services 36.99A, 36.99B and 36.99C are insured only when one of the following criteria is met:

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

10.2.2 The presence of dental disease adds a significant risk of complications to a planned open cardiac or organ transplant procedure or for patients with a compromised immune system or;

10.2.3 A child 17 years of age and under requires extensive dental rehabilitation and could not otherwise be treated due to the length of time for the treatment.

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- 10.3 Claims for anaesthetic services for intravenous sedation and physiologic monitoring may be claimed as benefit items 36.99A, 36.99B or 36.99C for patients in hospital, when such services are medically required.
- 10.4 Subject to 10.1, 10.2 and 10.3, if a patient has been admitted to hospital for dental extraction or another dental treatment procedure or an oral surgical procedure and the admitting physician does not administer a general anaesthetic:
- 10.4.1 pre-operative services shall be claimed under the appropriate hospital or office visit items (generally 03.03A, 03.04A, 03.04C) and
- 10.4.2 post-operative services shall be claimed under the appropriate hospital visit items 03.03D.
- 10.5 Subject to 10.1, 10.2 and 10.3, if a patient has been admitted to hospital for dental extraction or another dental treatment procedure or an oral surgical procedure and the admitting physician administers a general anaesthetic, the physician may claim hospital daily care for the days preceding and following surgery but not for the day of surgery. For the day of surgery, only the greater benefit of the anaesthetic service or the visit may be claimed.
- 10.6 Where applicable, physicians' services provided at the request of a dentist may be claimed as consultations, providing the provisions of GR 4 relating to consultations are met. With the exception of the services listed under GR 10.2, if the request relates to an uninsured dental service, neither a consultation or visit may be claimed.

11 LABORATORY/PATHOLOGY/RADIOLOGY

- 11.1.1 Claims for services under the pathology and radiology sections will not be payable unless the physician has been accredited by the College of Physicians and Surgeons of Alberta to provide those services.
- 11.1.2 The benefit rates listed in the Schedule which pertain to laboratory and pathology services including health service code '50.99A', may only be claimed for services provided to out of province Canadian residents.
- 11.2 ELECTROCARDIOGRAPHY/TAPE ECG/CARDIOVASCULAR STRESS TESTING

A claim for HSCs 03.52B, 03.52D, 03.55B and 03.56B may be submitted by physicians who have been approved by the College of Physicians and Surgeons of Alberta. For purposes of claims for HSC 03.52D, College of Physicians and Surgeons of Alberta approval for ECGs will be used as a proxy. A claim for HSCs 03.41A, 03.41B, and 03.41C, may be submitted only by physicians who have been approved by the College of Physicians and Surgeons of Alberta to provide these services.

11.2.1 PULMONARY FUNCTION PROCEDURES

Physicians performing procedures identified as Level I do not require approval from the College of Physicians and Surgeons of Alberta to perform these services. These services are reflected in health service codes 03.37A, 03.37B, 03.38D, 03.38E and 03.38R. Physicians performing

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procedures identified by the College as requiring either Level II, III or IV require approval and may only be claimed by physicians with the appropriate level of College approval.

In addition to Level I procedures, physicians with Level II approval may claim:

03.38A 03.38B 03.38C 03.38F 03.38G

In addition to Level I and Level II procedures, physicians with Level III approval may claim:

03.38H 03.38J 03.38K 03.38L 03.38M 03.38N
03.38P 03.38Q 03.38S 03.38T

In addition to Level I, II and III procedures, physicians with Level IV approval may claim:

03.38U 03.38V 03.38W

11.2.2 The College of Physicians and Surgeons of Alberta accredits facilities for the performance of Pulmonary Function Tests (PFT). With the exception of interpretive services, physicians may only perform Level II or higher PFT services in accredited facilities, and must ensure that claims submitted for these services include the applicable facility number. Claims for services provided in non-accredited facilities or hospitals as per GR 6.5 will not be paid.

11.3 DIAGNOSTIC IMAGING

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

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

11.3.3 Benefits are intended for diagnostic or therapeutic purposes. Mass screening services with the exception of health service codes X27C, X27D, X27E and X27F are not to be claimed.

11.3.4 OPAQUE MEDIA

Except as otherwise indicated in this schedule, the radiologic benefit listed includes the cost of opaque material used.

11.3.5 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.

Contralateral views of an opposite extremity when ordered by a radiologist, routinely or in an occasional case, shall be considered as part of the examination and the unilateral fee shall apply.

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11.3.6 COMPARATIVE VIEWS

If the referring physician requests imaging of a contralateral joint or extremity for comparative views, then an additional 50% may be claimed for the second side.

11.3.7 An entire extremity in infants and young children for such injuries as a wringer injury may be claimed only as the greater benefit for a single area of such extremity.

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

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

11.3.10 HEAD

Bilateral areas of the skull, such as mastoids, optic foramina, orbits and internal auditory meati shall include complete views of both sides. Sinuses should include all the sinuses. In each case, the benefit is a single amount for the region examined.

11.3.11 G.I. AND G.U. TRACT

Broad terms such as "upper gastro-intestinal tract", "barium swallow", "barium meal", etc. should be discarded in favour of the exact anatomical regions examined.

- a) A scout film taken on the same day as an intravenous pyelogram or gastro-intestinal examination shall be considered as part of that examination. Special scout films ordered by the referring physician may be claimed as separate examinations.
- b) The preliminary screening of the esophagus during a stomach and duodenum examination shall not constitute an esophogram. A complete radiographic and fluoroscopic examination of the esophagus when done with a complete and radiographic and fluoroscopic examination of the stomach and duodenum may be charged as a separate examination.

11.3.12 BREAST

When mammography is performed, ultrasound or real time scanning should not routinely be claimed.

11.3.13 INJECTIONS

Where injection of opaque material is not included as part of the radiological fee, the fee charged should be that listed under the appropriate section.

12 ANAESTHESIA

12.1 For the purpose of assessment of anaesthetic fees, each anaesthetic shall be considered as a separate and complete procedure.

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- 12.2 The anaesthetic benefit listed is for professional services, including pre-anaesthetic evaluation and post-anaesthetic follow-up and all immediate supportive measures. Consultations may not ordinarily be claimed when performed in the pre-operative period by a physician who administers the anaesthetic. Exceptions to this GR are where:
- 12.2.1 The consultation is not related to suitability for anaesthesia;
- 12.2.2 An admission visit and hospital daily care are payable when a family physician also functions as an anaesthetist.
- 12.3 In special cases where the attendance of more than one anaesthetist is medically necessary, the combined benefit which may be claimed by the two anaesthetists shall be 150% of that listed for the procedure.
- 12.4 Insofar as multiple surgical procedures are concerned, the principles that apply to payment of surgical benefits should also apply to payment of anaesthetic benefits. The exceptions to this are:
- 12.4.1 The surgical treatment of multiple benign skin lesions under anaesthesia of less than 35 minutes duration may only be claimed according to the appropriate single anaesthetic benefit.
- 12.4.2 The payment modifications for flaps and tissue resection procedures in reconstructive surgery do not apply to anaesthetic benefits.
- 12.4.3 In multiple fractures treated by closed reduction, the listed anaesthetic benefit for the major fracture plus 50% of the anaesthetic benefit for each other fracture shall apply.
- 12.4.4 In cases of compound fractures requiring extensive debridement, the listed anaesthetic benefit will be 50% greater.
- 12.4.5 If unrelated surgical procedures are performed by two physicians in a sequence in different anatomic areas utilizing the same anaesthetic, the anaesthetic benefit for the major procedure will be paid at 100% and the lesser at 75%.
- 12.4.6 Notwithstanding 12.4.5, when two physicians are operating simultaneously in different areas, only the greater anaesthetic benefit may be claimed.
- 12.4.7 Anaesthesia services for oral surgical procedures insured under the Schedule of Oral and Facial Surgery Benefits will be paid according to GR6.9.
- 12.4.8 The benefits that may be claimed for a redo cardiac, thoracic or vascular anaesthetic are as follows:
- a) 150% of the listed anaesthetic benefit if the procedure is performed entirely through a previous incision;
 - b) 125% if part of the procedure is performed through a previous incision.
- Refer to GR 6.15.
- 12.4.9 Notwithstanding GR 6.9.7e), a benefit may be claimed at the full rate for each fracture, which requires open reduction, continuous traction, or extensive skeletal fixation in addition to the full benefit for the major fracture.

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12.5 TIME RELEASE CLAUSE

- 12.5.1 Anaesthetic services provided in association with an unlisted procedure shall be claimed on a time basis.
- 12.5.2 When no anaesthetic value is listed in association with a procedure, claims shall be submitted on a time basis.
- 12.5.3 When multiple procedures are provided under the same anaesthetic, anaesthetic benefits may be claimed by time or by procedure, but not both.
- 12.5.4 The initial anesthetic time unit (ANEST) shall begin at the initiation of anesthetic service (time 0). Additional time units may not be claimed until a full five minutes has elapsed.
- 12.5.5 Additional time units (modifier ANU) may not be claimed until a full five minutes has elapsed.

12.6 Deleted

- 12.7 An additional benefit of \$100.00 per case (modifiers L30AN, L30AT, L30AT2, L44ANE) may be claimed for anesthetic services provided to neonates and infants under 44 weeks of conceptual age.

12.8 Deleted

13 SURGICAL ASSISTANCE BENEFITS

- 13.1 Claims for surgical assistance shall reflect the amount of time the assistant was required to assist the surgeon. Time claimed shall not exceed the anaesthetic time.
- 13.2 Surgical assistance benefits may not be claimed if an intern or resident is the first assistant.
- 13.3 Benefits may not be claimed for procedures that do not routinely require the services of a surgical assistant or a 2nd surgeon for a 2nd surgical team, unless supporting information detailing unusual circumstances satisfactory to the Minister is provided. Such procedures include but are not limited to the following list:

01.01A	01.03	01.04A	01.05A	01.09	01.12
01.14	01.22	01.24A	01.24B	01.32	01.34
02.84A	02.84B				
03.16A	03.19A	03.21A	03.22A	03.22B	03.25
03.26	03.29A	03.37A	03.38A	03.38B	03.38C
03.38D	03.38E	03.38F	03.38G	03.38H	03.38J
03.38K	03.38L	03.38M	03.38N	03.38P	08.38Q
03.38R	03.38S	03.38T	03.38U	03.38V	03.38W
03.41A	03.52A	03.52C	03.55A	03.56A	
06.35A	06.35B	06.39A	06.39B	07.09A	07.27A
07.27B	07.29A	07.29B	07.51A	07.51B	07.51C

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07.53A	07.53B	07.53C	07.53D	07.53E	07.54A
07.56A	07.57A	07.57B	09.01A	09.01B	09.01C
09.01F	09.05A	09.06A	09.07A	09.11A	09.12A
09.21A	09.22A	09.23A	09.24A	09.26A	09.26B
09.49A					
10.04	10.08A	10.16A	10.23	10.25	10.33A
10.33B	10.35	10.55A	10.56A	11.02	11.02A
11.81A	12.01	12.03	12.05	12.12A	12.12B
12.13A	12.21	12.23	12.24	12.31	13.01A
13.4 A	13.42A	13.53A	13.55A	13.57A	13.59A
13.59B	13.59C	13.59D	13.72A	13.99A	13.99AA
13.99B	13.99BB	13.99C	13.99D	14.21E	14.3 B
14.84	14.85A	14.85B	15.93A	15.93B	15.93C
15.94A	15.99A	16.2 B	16.81A	16.83A	16.83B
16.83C	16.89A	16.92A	17.03A	17.08D	17.08E
17.08K	17.1 A	17.1 B	17.39E	17.71A	17.81A
17.89A	18.29A	18.29B	19.81		
20.55B	21.0 A	21.2 A	21.31A	21.32A	21.32B
21.41	21.42	21.69A	22.11A	22.13A	22.13B
22.31	22.39	22.5 A	22.5 B	22.62A	22.71
22.81	22.9 A	23.99A	23.99C	23.99D	23.99E
24.22A	24.5	24.81	24.89A	24.89B	24.91
25.1 A	25.29	25.32	25.92	26.1	26.98A
27.3 A	27.4	27.5	27.5 A	27.7 A	27.7 B
27.7 C	27.7 E	27.72	27.73	28.1 A	28.4 A
28.5 A	29.39B	29.81	29.91		
30.19A	30.19B	30.81A	30.9 A	32.01A	32.1
32.31	32.81	33.01A	33.02A	33.03A	33.21A
33.22A	33.22B	33.4 C	33.51A	33.51B	33.61A
33.76A	33.76B	33.76C	33.76D	33.76E	33.76F
33.76G	33.89A	34.0 A	34.1 A	34.54A	34.89A
35.0 A	37.81	37.82A	37.82B	38.0 A	38.89A
38.89B	39.21A	39.62A	39.83A		
40.0	40.1	40.2	40.5	40.92A	41.29A
41.29B	42.09A	42.09B	43.1 B	43.81	43.82
43.95A	43.96A	43.96B	43.96C	43.96D	43.96E
44.01	44.22A	45.81A	45.83	45.84A	46.86A
45.88A	46.04A	46.04B	46.84A	46.88A	46.91
47.02B	47.03A	48.92A	48.98A	48.98B	
49.0	49.61B	49.7 D	49.73A	49.81	49.82A
49.82B	49.83A	49.84	49.85	49.86	49.93A
49.95A	49.96A	49.96B	49.98A	49.98B	49.98C
49.98D	49.98F	49.98G	49.98H	49.98J	49.98K
49.98L	49.98M	49.98N	49.98P	49.98Q	49.98R
49.98S	49.98T	49.98U	49.98V	49.98W	
50.4 A	50.6 B	50.71C	50.75E	50.79A	50.81A
50.81B	50.81C	50.81D	50.81E	50.82A	50.82B
50.83A	50.84A	50.84B	50.84C	50.87A	50.87B
50.87C	50.88A	50.89A	50.89B	50.89C	50.89D
50.89E	50.91A	50.91B	50.93A	50.94A	50.95A

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50.95B	50.96	50.97A	50.98A	50.99A	50.99D
51.49A	51.52A	51.53B	51.59B	51.65A	51.65B
51.92A	51.92B	51.93A	51.99A	51.99B	52.1 A
52.85A					
53.42A	53.81A	53.81B	53.83A	54.21A	54.21B
54.21C	54.21D	54.21E	54.89A	54.89B	54.89C
54.89D	54.89E	54.89F	54.91A	54.92A	54.92B
54.92C	54.92D	54.92E	55.41A	55.41B	56.34A
57.21A	57.92A	58.99B			
60.24A	60.82C	60.89A	61.01A	61.03	61.04
61.29A	61.32A	61.37A	61.39A	61.4 B	62.81A
62.82A	63.96B	63.99A	63.99B	63.99C	64.95A
64.97A	66.83	66.89A	66.89B	66.89C	66.91A
66.91B	66.91C	66.98A	67.02	67.81	67.83
67.86	67.87A	67.89A	67.93	67.96A	68.0 A
68.95	68.99A	68.99B	69.11	69.13D	69.29A
69.29B	69.29C	69.83A	69.83B	69.94	
70.1	70.2 A	70.2 B	70.2 H	70.4 F	70.4 G
70.5 A	70.5 B	71.8	71.95	71.96A	72.91
73.2 A	73.91	74.82A	75.64	75.83A	76.0
76.1 A	76.89A	76.91A	78.7 A	79.22	79.23A
79.29C	79.29E				
80.81	80.83B	80.85A	80.85B	81.01D	81.09
81.8	81.91A	81.96	82.0 A	82.12A	82.12B
82.12C	82.81A	82.91A	83.09A	83.2 B	83.7 A
84.21A	85.5 A	86.49A	87.3	87.53A	87.54A
87.54B	87.55A	87.6	87.99A	88.02A	88.92
89.98A					
91.00A	91.01A	91.01B	91.01H	91.01J	91.02A
91.02C	91.02D	91.03A	91.03B	91.04A	91.04B
91.05A	91.06B	91.06D	91.06E	91.07A	91.08B
91.08C	91.08J	91.12A	91.13A	91.13B	91.72
91.73A	91.73B	91.77C	91.78B	91.78C	
92.70	92.71	92.72	92.74	92.75	92.76
92.78A	92.78B	92.78C	93.91A	93.91B	95.03
95.81A	95.93	95.96A	96.01A	96.11A	97.81
97.83A	97.89A	97.89B	97.96	98.03A	98.03C
98.04A	98.04B	98.12A	98.12B	98.12C	98.12G
98.12J	98.12K	98.12L	98.12M	98.12N	98.12Q
98.12R	98.12S	98.12T	98.12U	98.13A	98.22A
98.22B	98.6 A	98.8 A	98.81A	98.81B	98.89A
98.89B	98.89C	98.89D	98.89E	98.89F	98.89G
98.92A	98.92B	98.92C	98.93A	98.93B	98.93C
98.96A	98.96B	98.96C	98.96D	98.98B	98.99A

13.4 Unless otherwise specified in this Schedule, surgical assistance benefits may not be claimed for performing ultrasound monitoring and guidance or other imaging during a procedure that is being performed by another physician.

14 TRAY SERVICE

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14.1 MAJOR TRAY SERVICE

A major tray service benefit may be claimed for the following procedures only when they are performed in a location other than a nursing home, general or auxiliary hospital or a facility which has a contract with a Regional Health Authority to provide any of these insured services.

01.01A	01.24A	01.24B	01.34	02.84A	02.84B
03.22B	03.25	07.53B	07.53D	07.53E	07.57A
12.31	13.59C	17.08A	17.81A		
21.42	21.69A	22.11A	22.13A	22.13B	22.31
22.5 A	22.62A	22.71	22.81	25.1 A	25.29
32.01A	32.81	33.02A	33.22B	34.0 A	34.1 A
34.89A	37.82A	38.89A	39.21A	39.62A	39.83A
40.92A	46.91	50.4 A	50.97A	52.1 A	52.11A
52.13					
60.24A	61.01B	61.03	61.04	61.29A	61.37A
61.39A	66.91A	70.1	70.5 A	72.91	75.64
79.23A					
82.81A	82.91A	83.7 A	89.37A	89.37B	89.41A
89.41B	89.42A	93.39B	93.39C	95.02A	95.09A
95.81A	97.11B	97.83A	97.89B	98.04A	98.6 A
98.6 B	98.12A	98.12B	98.12C	98.12H	98.12J
98.12M	98.12N	98.12Q	98.12R	98.12T	98.14A
98.22A	98.22B	98.81A	98.96A	98.96B	98.96C
98.96D					

14.2 MINOR TRAY SERVICE

A minor tray service benefit may be claimed for the following procedures only when they are performed in a location other than a nursing home, general or auxiliary hospital or a facility which has a contract with a Regional Health Authority to provide any of these insured services.

07.53C	07.56A	07.57B	10.16A	11.23A	13.53B
13.59E	13.59F	13.59H	13.59J	13.59K	13.99BB
17.71A	18.29E	19.81			
21.0 A	21.31A	21.32A	21.41	22.9 A	23.99D
23.99E	24.91	25.32	30.19A	32.96A	32.96B
33.01A	33.03A	33.21A	33.22A	33.61A	35.0 A
37.81	37.91A	38.0 A	39.91B		
43.0 B	43.0 C	50.98A	51.92A	53.81B	
61.01A	61.32A	67.93	70.5 B	71.95	73.91
78.7 A	79.22				
80.83B	81.8	93.91A	93.91B	94.01B	94.04
95.01A	95.03	95.93	95.94A	95.94B	95.96A
97.81	97.89A	98.01A	98.03A	98.03B	98.03C
98.04B	98.04C	98.12K	98.12S		

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14.3 MULTIPLE TRAY SERVICE

If multiple procedures listed under GRs 14.1 and 14.2 are performed during the same encounter in a location other than a nursing home, general or auxiliary hospital or a facility which has a contract with a Regional Health Authority to provide any of these insured services, the following applies:

- 14.3.1 For the same anatomical area (example - 3 moles removed from the face), only one tray may be claimed except when the condition relates to suspected cancer or infection, in which case, if required, additional tray(s) may be claimed at 50%.
- 14.3.2 For different anatomical areas, the tray for the initial procedure may be claimed at 100% and if required, the tray for each additional procedure may be claimed at 50%.
- 14.3.3 Benefits for additional trays may not exceed the benefit listed for one major tray.

15 OFF HOURS PREMIUM BENEFITS

- 15.1 In the case of physicians working exclusively in a hospital setting on either a full-time basis or as a part of their normal practice for a specified period of time (e.g. weekly hospital rotations among a practice group) off hours premium benefits may be claimed in accordance with the GRs for those claims as long as the claiming physician is the attending physician or is primarily responsible for the patient's care, or is claiming concurrent care in accordance with GR 4.8.
- 15.2 Physicians who are fulfilling a physician extender role (i.e., someone working on behalf of the attending or most responsible physician) may not claim for off hours premium benefits.
- 15.3 UNSCHEDULED SERVICES/SPECIAL CALLBACKS - HOSPITAL INPATIENT, OUTPATIENT AND EMERGENCY DEPARTMENTS

Benefits for UNSCHEDULED services (modifier SURC) and special callbacks 03.03L, 03.03MA, 03.03MB, 03.05P, 03.05QA and 03.05QB are intended to cover a degree of disruption that a physician would have to experience to provide such services during:
 - the evening on weekdays (1700 - 2200 hours),
 - the day and evening on weekends and statutory holidays (0700 - 2200 hours)
 - any night of the week (2200 - 0700 hours)
- 15.4 In situations where the physician initiates the service, the unscheduled service or special callback benefits may not be claimed. Claims may however, be made for the after hours time unit premium benefit (modifier SURT) under 03.01AA. See GR 15.13.
- 15.5 Only one unscheduled service or special callback benefit may be claimed for each encounter with a patient.
- 15.6 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.

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15.7 Claims for Unscheduled Services/Special Callback Benefits

- 15.7.1 Claims for the unscheduled service benefit (modifier SURC) must meet all of the following conditions:
- a) a special call for attendance is made on the patient's behalf;
 - b) the physician 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;
 - d) there is direct attendance by the physician.
- 15.7.2 Claims for special callbacks must meet all of the following conditions:
- a) a special call for attendance is made on the patient's behalf;
 - b) the physician responds to such a call from outside the hospital, on an unscheduled basis;
 - c) the patient is attended on a priority basis;
 - d) there is direct attendance by the physician.
- 15.8 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. However:
- a) time spent with subsequent hospital inpatients may be submitted under 03.05BA using modifier SURT;
 - b) for second and subsequent emergency/outpatients seen during the same callback, see GR 5.2.3.
- 15.9 The unscheduled service benefit (modifier SURC) may be claimed for the services outlined in GRS 15.9.1 through 15.9.3. It may also be claimed for these services when provided to second and subsequent patients seen during the same special call for attendance at the same facility.
- 15.9.1 selected "V" category code services:
- a) consultations, including telehealth (except those provided using store and forward videototechnology);
 - b) intensive care unit visits (HSC 03.05A);
 - c) psychiatric mental status determination requiring complete mental health status examination and investigation (HSC 08.11A);
 - d) certification under the Mental Health Act (HSC 08.12A);
 - e) trauma assessment, multiple trauma, severely injured patient - first day (HSC 13.99G);
 - f) hyperbaric oxygen therapy detention time (HSC 13.99I);
 - g) medical emergency detention (HSC 13.99J);
 - h) management of complex labor, per 15 minutes (HSC 13.99JA);
 - i) donor maintenance prior to cadaveric harvesting of organs (HSC 13.99L);
 - j) examination and crisis counseling for sexual/physical abuse (HSC 13.99V);
 - k) attendance at delivery (HSC 87.98E)
- 15.9.2 radiology, pathology and other diagnostic and therapeutic services if the physician is directly involved in the provision of services of an invasive nature;
- 15.9.3 procedures including surgical assists, obstetrical deliveries, anaesthesia, major surgery and minor surgery.
- 15.10 The unscheduled service benefit (modifier SURC) may not be claimed for:

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15.10.1 stand-by time;

15.10.2 services provided by physicians who are on-site and working a scheduled rotation duty shift in a hospital emergency department or providing first call coverage in an emergency department with greater than 25,000 visits per year;

15.10.3 additional procedures, i.e., those performed in association with another procedure;

15.10.4 non-invasive diagnostic procedures;

15.10.5 "V" category code services except for those listed under GR 15.9.1; and

15.10.6 Services included in the following list unless supporting information detailing unusual circumstances satisfactory to the Minister is provided.

03.21A	03.22A	03.22B	03.25	03.29A	07.29B
07.51A	07.51B	07.51C	07.54A	07.56A	13.42A
13.53A	13.57A	13.59A	13.59B	13.59H	13.59J
17.1 B	17.81A				
21.69A	22.11A	22.13B	22.31	22.71	22.81
23.99D	23.99E	24.81	24.91	26.91A	29.91
30.19A	30.81A	32.1	32.81	33.21A	33.22B
33.51A	37.82A	37.82B	38.89A	39.21A	39.62A
39.83A					
40.92A	41.29A	50.97A	51.92A	52.1 A	52.11A
52.11B	52.12	52.13			
60.82C	61.04	61.29A	61.32A	69.83A	69.83B
73.2 A	75.83A	76.1 A	79.22	79.23A	79.29E
81.91A	82.81A	82.91A	83.2 B	83.7 A	87.99B
95.81A	95.94A	95.94B	97.11A	98.12A	98.12B
98.12C	98.12J	98.12K	98.12L	98.12M	98.12N
98.12Q	98.12R	98.12T	98.8 A	98.81A	98.81B
98.99A					

15.11 MAXIMUMS FOR SPECIAL CALLBACKS

15.11.1 A maximum of five (5) special callbacks, either 03.03K, 03.05N or any combination thereof may be claimed, per physician, in any given weekday day. The weekday day is defined as Monday - Friday (0700 - 1700 hours).

15.11.2 A maximum of five (5) 03.03L, 03.05P or any combination thereof may be claimed, per physician, in any given weekday, Monday - Friday (1700 - 2200 hours).

15.11.3 A maximum of fifteen (15) 03.03L, 03.05R or any combination thereof may be claimed, per physician, on any day of the weekend or statutory holiday, (0700 - 2200 hours).

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- 15.11.4 A maximum of two (2) 03.03MA, 03.05QA or any combination thereof may be claimed, per physician, any day, (2200 - 2400 hours).
- 15.11.5 A maximum of seven (7) 03.03MB, 03.05QB or any combination thereof may be claimed, per physician, any day, (2400 - 0700 hours).
- 15.11.6 Deleted
- 15.12 ROTATION DUTY OFF-HOURS SERVICES AND FIRST CALL COVERAGE IN THE EMERGENCY/ OUTPATIENT DEPARTMENT IN HOSPITALS WITH GREATER THAN 25,000 VISITS TO THE EMERGENCY ROOM PER YEAR.
- 15.12.1 Rotation duty off-hours benefits may only be claimed by physicians who are on-site and working a scheduled rotation duty shift in the emergency department or by physicians who are providing first call coverage in an emergency department that has greater than 25,000 visits to the emergency room per year. See GR 15.13 for an explanation of claiming for the after hours time unit premium benefit.
- 15.12.2 Except as noted in GR 15.12.1 and in the case of physicians who are specially called to the hospital emergency/outpatient department to attend their patient and have already reached the maximums outlined in GR 15.11, rotation duty off-hours benefits may not be claimed by physicians who are providing on-call coverage. Refer to GR 5.2.
- 15.12.3 Only one scheduled rotation duty off-hours benefit may be claimed for each encounter with a patient.
- 15.12.4 A scheduled rotation duty off-hours benefit may only be claimed when there is direct attendance by the physician.
- 15.12.5 The scheduled rotation duty off-hours benefit (modifier SURC - prefix RD) may be claimed for the services outlined in GRs 15.12.6 and 15.12.7.
- 15.12.6 selected "V" category code services:
- a) consultations, including telehealth (except those provided using store and forward videototechnology);
 - b) certification under the Mental Health Act (HSC 08.12A);
 - c) critical care of severely ill or injured patient in a hospital emergency department requiring major treatment intervention(s) (HSC 13.99H);
 - d) hyperbaric oxygen therapy detention time (HSC 13.99I);
 - e) medical emergency detention (HSC 13.99J);
 - f) management of complex labor, per 15 minutes (HSC 13.99JA)
 - g) donor maintenance prior to cadaveric harvesting of organs (HSC 13.99L);
 - h) examination and crisis counseling for sexual/physical abuse (HSC 13.99V);and
 - i) attendance at delivery (HSC 87.98E).
- 15.12.7 procedures including obstetrical deliveries, anaesthesia, major surgery and minor surgery.
- 15.12.8 The scheduled rotation duty off-hours benefit may not be claimed for:
- a) stand-by time;
 - b) additional procedures, i.e., those performed in association with another procedure;
 - c) non-invasive diagnostic procedures;

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- d) critical care of severely ill or injured patient in a hospital emergency department requiring major treatment intervention(s) (13.99H) by a second physician who, due to a shift change, has taken over care of a patient and
- e) category code "V" services except for those listed under GR 15.12.6.

15.12.9 See GR 15.13 for services eligible for the after hours time unit premium benefit.

15.13 AFTER HOURS TIME PREMIUM - HOSPITAL INPATIENT, OUTPATIENT AND EMERGENCY DEPARTMENTS, AUXILIARY HOSPITALS AND NURSING HOMES

- 15.13.1 Benefits for the AFTER HOURS TIME PREMIUM (modifier SURT) are intended to provide physicians with compensation for services provided after hours during:
- the evening on weekdays (1700 - 2200 hours),
 - the day and evening on weekends and statutory holidays (0700 - 2200 hours),
 - any night of the week (2200 - 0700 hours).
- 15.13.2 The after hours time premium modifier applies to both scheduled and unscheduled services. In the case of unscheduled services, the unscheduled services modifier will also apply according to GRs 15.3 through 15.10.6.
- 15.13.3 In the case of rotation duty and in the case of services in hospital emergency departments with greater than 25,000 visits per year, the rotation duty off-hour benefit will also apply in accordance with GR 15.12.
- 15.13.4 The after hours time premium modifier is to be claimed on a per 15 minute basis beginning at the time of contact with the patient and may only be claimed for direct patient care time related to the provision of an insured service. The after-hours time premium units may not be claimed for stand by time, e.g. time spent waiting for results of diagnostic tests.
- 15.13.5 Time for the after hours time premium may be determined on a cumulative basis, and claimed according to the time period(s) in which the majority of the service occurred. Health service code 03.01AA should be used to claim the after-hours time modifier for all services other than second and subsequent in-patients seen after a special callback, which should be claimed using 03.05BA. In the case of a procedure performed for a second and subsequent in-patient, use 03.01AA.
- 15.13.6 In the event that one 15 minute period covers two time periods, the modifier claimed will be based on the time period where the majority of the 15 minute period occurred.
- 15.13.7 In the event that the time spent with the patient covers more than one time period, additional modifiers may be claimed, each according to the time spent with the patient in that particular time period.
- 15.13.8 The after hours time premium modifier may be claimed for second and subsequent patients seen at the same special callback to hospital inpatient using 03.05BA.

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- 15.13.9 The after hours time premium modifier may not be claimed for:
- stand-by time;
 - additional procedures, i.e., those performed in association with another procedure;
 - non-invasive diagnostic procedures;

15.13.10 The maximum number of after hours time premium modifiers per hour, per physician is 4.

16 Deleted

17 TELEHEALTH

17.1 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 1.10 but does not include the "physical examination" requirements referred to under GR 4.1.

17.2 Deleted

17.3 Deleted

17.4 "Store and forward" videotechnology applies only to teledermatology telehealth services and teleophthalmology consultations (health service code 03.09B).

17.4.1 Deleted

17.4.2 Services provided using store and forward videotechnology are not eligible for unscheduled service benefits.

17.5 Telehealth services provided at the request of a non-physician other than a midwife, podiatrist, dentist, optometrist or nurse practitioner may not be claimed as consultations; payment will be made at the non-referred visit rate.

17.6 Services claimed using the telehealth modifier must meet all of the requirements outlined in the applicable GR's except as outlined in GR 17.1.