Billing Corner

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Billing Corner is also available on the Alberta Medical Association website
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AMENDED March 23, 2020
Includes Virtual Care Codes

March 2020

Please read this document and then share with your billing staff

Please ensure that your billing software has been updated to reflect the changes that are described within this document. The Billing Corner is a summary document.

Alberta Health Care Insurance Plan
Schedule of Medical Benefits
Effective March 12, 17 and 31, 2020

Disclaimer: *While care has been taken to provide accurate information, the Alberta Medical Association does not warrant or guarantee the accuracy of the information contained herein. Please refer to the Schedule of Medical Benefits for complete details. If you provide services specific to more than one section, the AMA recommends that you refer to all those that are applicable to the services that you provide.*

Table of Contents

Virtual care codes	3
Adjust Complex Patient Modifiers – Rescinded on March 17, 2020 (MED 209)	7
Telephone/Email/Videoconference Advice during COVID-19 (MED 221)	7
De-list Comprehensive Care Plans 03.04J (MED 210)	7
De-insure Drivers Medical 03.05H (MED 211)	8
De-insure Imaging when Referred from Uninsured Practitioners (MED212)	8
Diagnostic Imaging Appropriateness (MED 213)	8
Daily Volume Caps (MED 220)	9
Reduction of Overhead in Publically Funded Facilities - The "Z" Codes (MED 215)	10
Removal of Clinical Stipends	11
Claims Submission to 90 Days (GEN 123)	11
Standardize payments for non-invasive diagnostic services in AHS facilities	11
Stop Accepting Good Faith Claims (GEN 122)	11
Continuing Medical Education Program (CME) (MED 219)	12
Medical Liability Reimbursement Program (MLR) (MED 218)	12
Rural Remote Northern Program (RRNP) (MED 217)	12
Business Cost Program (BCP) (MED 216)	13

Virtual care codes

New codes are being introduced on a temporary basis and will remain in place as long as the Chief Medical Officer of Health determines appropriate. **The codes are retroactive to March 17, 2020. Physicians are asked to hold their claims for these services until AH can properly program the claims system. A notice will be issued once physicians can submit their claims.**

These codes are a good step in terms of introducing virtual care codes into practice during this time. The AMA and Alberta Health will continue to monitor and adjust these codes on a regular basis, as appropriate.

The codes are as follows:

Visit Services – HSCs: 03.03CV and 03.03FV
Consultation Services – HSCs: 03.08CV and 08.19CX
Mental Health Services – HSCs: 08.19CV and 08.19CW

Health Service Code 03.01AD remains as amended March 18, 2018 – see page 7 of this Billing Corner

The following rules will apply to the virtual care codes listed above:

- Must be initiated by the patient or their agent, meaning that the patient or their agent has either booked the appointment or requested to see the physician virtually. Any arrangements the physician or their staff make in order to accommodate a virtual visit/consultation is at the request of the patient.
- Physician must provide the service
- Patient record must reflect a detailed summary of the service. Be sure to include all elements and differentiate records between patients. In the event of an audit, AH will reduce the service to the lowest visit service possible.
- Record start and stop time of the virtual visit in the patient record, this is not to be reported on the claim that you submit to AH.
- Unlike other visit and consult services, AH has stated that only direct physician to patient time can be claimed. Time spent on administrative tasks cannot be claimed.
- One virtual visit per patient, per physician per day may be claimed.
- Cannot be billed with other virtual services or in-person services provided on the same day.
- Additional premiums such as age modifiers, complex modifiers, after hours time premium, Business Cost Program (BCP) and Rural Remote Northern Program (RRNP) will not apply to virtual codes.
- These codes will NOT count towards the daily cap, set for introduction on March 31
- Virtual services that are 10 minutes or less MUST be claimed using 03.01AD.
- If the patient consults the physicians about COVID-19 or discusses the virus at the same time as other medical services, please add the Dx 079.8(2) to the claim for tracking purposes.

VISIT SERVICES:

03.03CV Assessments provided by General Practitioners (GP) and Specialists via telephone or secure videoconference.

Information:

- The service must include a limited assessment of a patient's condition requiring a history related to the presenting problem(s), appropriate records – including start and stop time
- Details relevant to the service must be recorded in the patient record
- The visit MUST last a minimum of 10 minutes
- Paid at the 03.03A rate for each specialty. See the Fee Navigator® for 03.03A for detailed information.

Example:

Physician has a virtual visit with a patient regarding diabetes management, the visit lasts 5 minutes.
Claim: 03.01AD Dx code 079.8(2) (the Dx code as stated from AH) and 250 (diabetes)

The same physician has a virtual visit with a patient regarding hypertension management, the visit last 17 minutes
Claim: 03.03CV Dx code 410

In both instances the start and stop time for the service must be recorded in the patient record AND the details of the discussion, history and examination must be recorded in the patient record.

03.03FV Follow up assessments (visits), for referred patients only, provided by specialists via telephone or secure videoconference.

Information:

- The service must include a limited assessment of a patient's condition requiring a history related to the presenting problem(s), appropriate records – including start and stop time
- Details relevant to the service must be recorded in the patient record
- The visit MUST last a minimum of 10 minutes
- Paid at the 03.03F rate for each specialty. See the Fee Navigator® 03.03FA for detailed information.
- 03.03FA is NOT billable in addition
- Only specialties that are currently listed under 03.03F can bill 03.03FV

Example: A pediatrician completes an assessment of a child; the service lasts 35 minutes.

Claim: 03.03FV – remember no prolonged visit codes are applicable nor can they be billed in addition to the 03.03FV.

03.08CV Comprehensive consultations provided via telephone or secure videoconference.

Information:

- Patient must be referred by an eligible referring provider (see consultation requirements in Rule 4.4.1) and remaining consultation requirements fulfilled
- Physician must complete a comprehensive assessment of a patient's condition requiring a complete history, appropriate records, advice to the patient, and a written report to the referring physician or eligible practitioner
- Prolonged codes are not billable in addition to 03.08CV
- Surcharge modifiers and time premiums are not billable for the service
- The rate is equal to the 03.08A for each specialty

Example:

Physician completes a virtual consult with the patient, the consult lasts 35 minutes.

Claim: 03.08CV

08.19CX Comprehensive psychiatric consultation provided via telephone or secure videoconference.

Information:

- Consultation requirements for referral by eligible provider must be met
- Only billable by PSYC and GNMH
- Physicians must complete a comprehensive assessment of a patient's condition requiring a complete history, appropriate records, advice to the patient, and a written report to the referring physician or eligible practitioner.
- Record details in patient record, including start and stop time
- Additional time 15 minute units may be claimed using the calls field. See GR 2.3.4 for more information.
- Will be paid at the rate that is listed in the Price List for 08.19A.

Example: A psychiatrist has a virtual comprehensive consult with a patient, the service lasts 53 minutes.

Claim: 08.19CX 3 calls

08.19CV Psychotherapy and other psychiatric services (such as group therapy) provided via telephone or secure videoconference by a Psychiatrist or a Generalist of Mental Health

Information:

- Only billable by PSYC and GNMH
- For psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or psychiatric counselling
- Record details in patient record, including start and stop time
- Additional time 15 minute units may be claimed using the calls field. See GR 2.3.4 for more information.
- Will be paid at the rate that is listed in the Price List for 08.19GA for each specialty

Example: A psychiatrist has a virtual psychotherapy session with a patient, the service lasts 38 minutes.

Claim: 08.19CV 3 calls

08.19CW Psychotherapy and other psychiatric services (such as group therapy) provided via telephone or secure videoconference by a GP and Pediatrician

Information:

- Billable by GP and PED
- For psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or psychiatric counselling
- Record details in patient record, including start and stop time
- Additional time 15 minute units may be claimed using the calls field. See GR 2.3.4 for more information.
- Will be paid at the rate that is listed in the Price List for 08.19G for each specialty

Example: A GP has a virtual psychotherapy session with a patient, the service lasts 38 minutes.

Claim: 08.19CW 3 calls

To bill the electronic codes, there is a requirement for adherence to CPSA guidelines and possibly the need for an amendment to the physician's PIA. Please contact Caroline Garland, EMR Advisor, at the AMA to discuss requirements if needed: caroline.garland@albertadoctors.org, cell # 587-987-5258.

Additional information regarding virtual care may be found on the AMA's virtual care page: https://www.albertadoctors.org/leaders-partners/ehealth/virtual-care

The **telehealth modifier (TELES) does NOT apply to these codes. The TELES modifier may only be used** for services that are provided using telehealth technology as defined in GR 1.10.

The AMA's ***Fee Navigator***® will be updated as soon as possible. Please contiue to use the ***Fee Navigator***® for all details on codes.

Further information on the following Alberta Health Bulletins can be found here: https://www.alberta.ca/bulletins-for-health-professionals.aspx?utm_source=redirector

Adjust Complex Patient Modifiers – Rescinded on March 17, 2020 (MED 209)

Please Note: The proposed changes to the time requirements and payment rates for complex patient modifiers were rescinded by Alberta Health on March 17, 2020, and **will not be going forward** on March 31, 2020, **NO CHANGES TO THE FOLLOWING:**

- CMXC modifier – for comprehensive visit and consultation services
- CMXV modifiers –for other specialist visit services
- CMGP modifier – time requirements or payment for General Practitioner visit services

Telephone/Email/Videoconference Advice during COVID-19 (MED 221)

Effective March 12, 2020, to minimize the risk of exposure to the COVID-19 virus 03.01AD was activated. 03.01AD can be used to bill for providing advice via telephone, email, and videoconference including virtualcare, reminder that when using email and videoconference systems, they MUST be in compliance with the CPSA guidelines on secure electronic communication and when the physician/clinic has submitted a Privacy Impact Assessment for this service acceptable to the Office of the Privacy Commissioner of Alberta.

When can a physician submit claims for HSC 03.01AD?

- 03.01AD is NOT limited to patients with diagnosed or suspected COVID-19.
- Providing care in relation to COVID-19.
- Providing care for any non-COVID-19 related conditions to any patient for services that are less than 10 minutes. Start and stop time to be recorded in the patient record.
- There is NO cap on the number of claims a physician can submit for 03.01AD.
- May only be claimed when the physician provides the phone call.
- May only be claimed once per patient, per physician, per day.
- The daily cap coming into effect on March 31, 2020 will NOT apply to 03.01AD.
- 03.01AD will remain active as long as the Chief Medical Officer of Health determines it should remain active.

For updates to this bulletin, see this page: https://www.alberta.ca/bulletins-for-health-professionals.aspx

De-list Comprehensive Care Plans 03.04J (MED 210)

Health Service Code 03.04J – Development of a Comprehensive Annual Care Plan – is de-listed from the Schedule of Medical Benefits. Claims for 03.04J submitted on March 31, 2020 or later will not be paid.

Comprehensive care planning is still considered an insured service and if provided can be claimed as a part of 03.04A when all of the criteria for 03.04A have been met.

De-insure Drivers Medical 03.05H (MED 211)

Driver's Medical Examination for Patients 74.5 Years of Age or Older – is de-insured from the Schedule of Medical Benefits.

Physicians must advise patients 74.5 years of age or older of the cost for the exam before starting the exam. Please consult the AMA's *Guideline to Billing Uninsured Services* available on the AMA website (login required).

De-insure Imaging when Referred from Uninsured Practitioners (MED212)

Patients who are referred for imaging services by a chiropractor, physiotherapist, or audiologist are not payable under the Alberta Health Care Insurance Plan, fees for these services are the responsibility of the patient.

- Chiropractors, Physiotherapists, and Audiologists will have to inform their patients of the costs for these services.

Diagnostic Imaging Appropriateness (MED 213)

Health Service Codes X301, X303, X311, X315, X316, X317, X318, and X319 will be amended to preclude specific combinations of services. Physicians are advised to adhere to the following billing restrictions:

- X301 - May not be claimed with X338
- X303 - Max of one call
- X311 - May not be claimed with X312, X314 or X315
- X315 - May not be claimed with X311 or X324
- X316 - May not be claimed with X312 or X324
- X317 - May not be claimed with X324
- X318 - May not be claimed with X314
- X319 - May not be claimed with X314

Daily Volume Caps (MED 220)

Daily patient volume payment rules will apply to all visit services with a "V" category code that are provided in a physician office. There are two "V" category codes that will be exempt from capping rule, 13.82A Psoralen ultraviolet A treatment, ultraviolet B or narrow-band ultraviolet B treatment and 03.01AD, telephone advice to a patient or their agent regarding viral outbreak. For all other "V" category codes the discount rate will be applied as follows:

Daily Range (visits)	Discount Rate
0 to 50	0%
51 to 65	50%
65 and greater	100%

The daily patient volume payment rules will not apply to services provided in rural communities, hospitals, and emergency rooms. Physician offices located outside the following locations will be considered rural:

Edmonton	Sherwood Park	St. Albert	Devon	Stony Plain
Leduc	Fort McMurray	Grand Prairie	Airdrie	Red Deer
Calgary	Medicine Hat	Lethbridge		

Reduction of Overhead in Publically Funded Facilities - The "Z" Codes (MED 215)

Alberta Health is introducing a set of codes that are paid at a reduced rate as they have stated that "physicians are no longer eligible to receive compensation for overhead when a service is provided in a publically funded facility. The overhead expenses have already been paid for with public dollars." They have not published the rates for these codes but they have indicated that they have used the following calculation: the difference in the PBCM 2015 AMA calculation of overhead and the AHS 2015 calculation of overhead. Once the rates are published, the AMA will update billing information as appropriate.

The following codes will not be billable when the service is provided in a publically funded facility:

03.03A	03.03B	03.03F	03.04A	03.05I	03.07A
03.08A	03.08B	03.08I	03.08J	08.19A	08.19G
08.19GA	08.45				

These codes will be replaced with:

The following codes will replace the codes above for services provided in a publically funded facility:

03.03AZ	03.03BZ	03.03FZ	03.04AZ	03.05IZ	03.07AZ
03.08AZ	03.08BZ	03.08IZ	03.08JZ	08.19AZ	08.19GZ*
08.45Z					

The 08.19G and 08.19GA will be rolled up into the 08.19GZ code.

Publically funded facilities are:

- Active Treatment Centre
- Ambulatory Care Centre
- Auxiliary Hospital
- Health Canada Nursing Station
- Community Mental Health Clinic
- Nursing Home
- Regional Contracted Practitioner Office (a facility that has a contract with AHS to provide specific services)
- Subacute Auxiliary Hospital
- Urgent Care Center
- Advanced Ambulatory Care Centre

Removal of Clinical Stipends

AHS has indicated they **will not stop the clinical stipends before August 2020** unless physicians have been notified otherwise. More information to follow.

Claims Submission to 90 Days (GEN 123)

The time limit for practitioners to submit claims to Alberta Health for services provided in Alberta changes from 180 days to **90 days**.

Any outstanding claims submitted after 90 days (and within 180 days of the service date) for services performed prior to March 31, 2020, will require manual adjudication. These claims will require text indicating the service was performed prior to the March 31 submission time limit change.

The AMA suggests that you ensure that your claims submissions are up-to-date by March 30 to avoid any delays in payment.

Requests to consider extenuating circumstances in relation to outdated claims are reviewed on a case-by-case basis. Examples of extenuating circumstances are disasters where records have been destroyed (fire/flood), fraud, theft of computer or paper records, and claims refused by the Workers' Compensation Board.

Standardize payments for non-invasive diagnostic services in AHS facilities

The AMA does not have any additional details about this proposal at this time.

Stop Accepting Good Faith Claims (GEN 122)

Claims made under the Good Faith Policy will no longer be paid. Physicians will have to verify coverage of the patient prior to submitting a claim. If proof of eligibility is not provided, physicians may consider collecting payment from the patient and submitting a pay-to-patient claim. You may charge the patient the listed rate in the SOMB and submit a pay to patient claim to Alberta Health using the patient demographic information, including their PHN, provided. If the information provided by the patient is accurate and the patient has coverage at the time of the service or has it backdated to the date of service, the patient will receive a cheque in the mail (to the address Alberta Health has for the patient) for the amount that was paid. See the Physician's Resource Guide for more information.

In an AHS facility, physicians are obligated to see patients without the requirement for compensation. In a private clinic, physicians are not obligated to see patients who cannot pay or provide proof of coverage.

To help reduce the number of claims refused due to problems with a patient's eligibility for benefits, always verify that your patient has AHCIP coverage.

- Physicians and office staff can verify a patient's eligibility using the person directory on Alberta Netcare. For more information on Alberta Netcare, see www.albertanetcare.ca
- Alberta Health provides a 24-hour interactive telephone inquiry service to check a patient's eligibility for coverage and validity of their PHN. To use the service phone 780-422-6257 in Edmonton, or from outside Edmonton call toll-free 1-888-422-6257.

Continuing Medical Education Program (CME) (MED 219)

The following changes to CME will be made:

- Alberta Health funding for CME will end.
- Physicians will no longer be reimbursed for costs that are currently covered by the CME program through Alberta Health funds.
- If you have not already done so, and have outstanding CME credits, you may still submit your claims for reimbursement up to March 31, 2020

Medical Liability Reimbursement Program (MLR) (MED 218)

The following changes to the MLR program will be made:

- Funding will be based on a fixed funding amount paid to the Alberta Medical Association (AMA).
- The AMA may choose to revise the amount paid for each physician's deductible.

Rural Remote Northern Program (RRNP) (MED 217)

There are no changes until March 31, 2021.

Effective March 31, 2021, the following changes to RRNP will be made:

- Flat Fee (FF) payments will be eliminated.
- The Variable Fee Premium (VFP) payment component will be maintained and a new eligible community list and new percentage for each eligible community may be assessed and changed,
- Through a consultation process with the AMA, the eligible community list will be revised.

Business Cost Program (BCP) (MED 216)

There are no changes until March 31, 2021.

Effective March 31, 2021, the following changes to the BCP will be made:

- BCP payments will be made at the rate of one BCP base payment per eligible claim.
- BCP payments for subsequent calls and modifiers associated with claims will be discontinued.
- All other program parameters will remain the same.