



ALBERTA MEDICAL ASSOCIATION

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How to Optimize AHW Billing April 2010 Changes

Banff - February 2010



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Consultant Fees



Understanding the Schedule

- Fees change - Read all Bulletins
 - Ensure staff have copies
- Stay up-to-date
 - Request new SOMB (780 427-1093)
 - Explanatory codes
- **Physician decides on the code to submit to AHW**



April 1, 2010 Changes

- 03.05LA Group session, multiple patients, where a physician is involved in providing care and teaching to patients in attendance \$15.62
 - Not be claimable in addition to a visit at the same encounter.

- 58.99F Manual disimpaction of stool \$100.00
 - Claimable in addition to a visit or consultation



Comprehensive Geriatric Assessment

- 03.04K Comprehensive geriatric assessment first 1.5 hours \$300.00
 - Each addition 15 min (max 5 add) \$ 50.00
 - Less than 1.5 hrs – 03.08A or 03.04A
 - Regional facility
 - Once/pat/year – 75 & over
 - Restricted to GP, IM, Geriatric medicine
 - Assessment includes
 - Medical - complete physical, problem list, med review
 - Functional – review basic activities, exercise, gait
 - Cognitive – Mini mental
 - Social – informal support needs
 - Environmental – review of current living situation



Comprehensive Care Plan

- 03.04J Development, documentation & administration of a comprehensive annual care plan for patient with complex needs \$217.38
 - Family physician most responsible
 - One/patient/year with ongoing communication
 - May be claimed in addition to 03.03A, 03.03N, 03.04A
 - Complex – patient with multiple complex health needs including chronic disease and other complications
 - Two or more diagnosis from group A & B



Comprehensive Care Plan cont'd

- Group A
 - Hypertensive disease (401)
 - Diabetes Mellitus (250)
 - COPD (496)
 - Asthma 493)
 - Heart Failure (428)
 - Ischemic Heart Disease (413 - 414)
- Group B
 - Mental Health Issues (290 – 319)
 - Obesity (Adult + BMI 35, Child = BMI 97 percentile) (278)
 - Addictions (303 – 304)
 - Tobacco (305.1)



Comprehensive Care Plan cont'd

- Care plan includes
 - Direct contact with patient
 - Clearly defined goals – mutually agreed to
 - Detailed review of chart, current therapies and problem list
 - Demographic information that may affect patient health &/or treatment
 - Incorporate patient values & personal goals
 - Expected outcome
 - Identification of other health care professions that may be involved
 - Patient must have a copy & copy in chart



Phone Advice (April /10 rates)

Patient care advice to active treatment facility worker in relation to the obstetrical outpatient

03.01LM	(M-F 0700 – 1700)	\$17.71
03.01LN	(M-F 1700 – 2200)	
	(W/E 0700 – 2200)	\$26.16
03.01LO	(2200 – 0700)	\$30.87



Phone advice (April /10 rates)

Phone advice to paramedic, assisted living/designated living and lodge staff, active treatment facility worker (in patient), long term care worker, nurse practitioner, home care worker via telephone or other telecommunication method

- Different rules for each

03.01NG	(w/d 0700 – 1700)	\$16.95
03.01NH	(w/d 1700 – 2200) or (w/e 0700 – 2200)	\$25.03
03.01NI	(2200 – 0700)	\$29.54



Phone advice (April /10 rates) cont'd

Home care advice provided to community mental health worker

03.01B	(w/d 0700 – 1700)	\$16.95
03.01BA	(w/d 1700 – 2200) or (w/e 0700 – 2200)	\$23.92
03.01BB	(2200 – 0700)	\$28.22



Rules for Phone advice

- Must be initiated by worker
 - Except LTC may be physician initiated
- Maximum 2/patient/physician
- May be claimed in addition to other services SDOS
- Documentation required
- LTC & Active Rx worker – physician must be outside the facility
 - Active Rx facility worker – in patient or OB outpatient only
- Nurse practitioner – must be in independent practice or working at nsg station with no physician present
- Home care – may be in person & must be administered by RHA



Physician to physician telephone or telehealth videoconference advice (April /10 rates)

Referring physician

03.01LG	w/d	0700 – 1700	\$35.50
03.01LH	w/d	1700 – 2200 or	
	w/e	0700 – 2200	\$52.54
03.01LI		2200 – 0700	\$62.01

Claimable when:

- Consultant provides opinion & recommendations for pat Rx & management
- Purpose of call is to seek advice of a physician more experienced in treating particular problem
- Patient remains in care of referring physician

Not claimable when purpose of call is to:

- Arrange for transfer within 24 hours unless patient transferred to an outside facility and advice was given re management prior to the transfer
- Arrange for an expedited consultation or procedure within 24 hours
- Arrange for lab or DI investigations
- Discuss or inform referring physician of results of diagnostic information

Max 2/day/pat/physician – documentation required

Telehealth videoconference both physicians must be at regional telehealth facility

Payable in addition to the visit



Physician to physician telephone or telehealth videoconference advice (April /10 rates)

Consultant (must be practicing physician – not resident)

03.01LJ	w/d	0700 – 1700	\$ 74.18
03.01LK	w/d	1700 – 2200 or	
	w/e	0700 – 2200	\$109.80
03.01LL		2200 – 0700	\$129.58

Claimable when:

- Call initiated by referring physician
- Consultant provides opinion & recommendations for pat Rx & management

Not claimable when purpose of call is to:

- Arrange for transfer within 24 hours unless patient transferred to an outside facility and advice was given re management prior to the transfer
- Arrange for an expedited consultation or procedure within 24 hours
- Arrange for lab or DI investigations
- Discuss or inform referring physician of results of diagnostic information

Max 2/day/pat/physician – documentation required

Telehealth videoconference both physicians must be at regional telehealth facility



Visits with Procedures

Minor procedure (M) and office visit

- Procedure includes removal of sutures
 - Same physician
 - Same practice group
- Local infiltration included in the benefit
- Both payable if unrelated Dx code

Minor procedure & hospital visit

- Greater only



Visits with Procedures cont'd

Exceptions to the visit + procedure rule

- 93.91A (joint injection, hip) - office only
- 93.91B (joint injection other joints) - office only
- 98.12L (Rx of warts) - any location
- 13.99BA (Pap smear) - any location
- 10.16A (Pessary fitting) - any location
- 81.8 (IUD) - any location
- 79.22 (Cautery of cervix) - any location
- 79.23A (Cryotherapy cervix) - any location



Visit & Procedure Exceptions cont'd

- 13.59A IM or Subcutaneous injections - any location
- 51.92 Varicose vein injection - any location
- 98.03A I&D of abscess or hematoma, subcutaneous or sub mucous - any location
- 98.12C Removal of sebaceous cyst - any location
- 98.12J Removal or excision (warts, keratoses) - any location



Visit & Procedure Exceptions cont'd

- April /10 new exception to the visit + procedure rule
 - 93.91A (joint injection, hip) - any location
 - 93.91B (joint injection other joints)
 - any location
 - 58.99F Manual disimpaction of stool



Diagnostic Surgical Proc's (+) (GR 6.6)

- Office
 - “+” And visit - both payable
 - “+” And consultation - both payable
- Hospital
 - “+” And visit - greater only
 - “+” And consultation - both payable



Complex Care April /10 Rates

CMGP

- CMGP - Complex patient consultation/visit – first 15 minutes and then in 10 minute increments to a maximum of 6 units
\$15.70/unit
 - Complex patient requiring that physician spend 15 minutes or more on management of patient care
 - Second & subsequent units only billable when **full** 10 minutes
 - Claimable with **03.01J**, 03.03A, 03.03B, 03.03C, **03.03N**, **03.03P**, **03.03Q**, 03.07A, 03.07B
 - Example 03.03A for 45 minutes 03.03A CMGP04



Complex Care (April / 10 rates) cont'd

CMXC30 – Complex patient consultation/visit
\$29.99

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



Activities that contribute to CMX

- Complexity based on time
- Activities to include in calculation of time
 - Review of patient chart prior to seeing patient
 - Talking to & examining patient
 - Charting
 - Review of any lab or DI investigations
 - Dictation of referral letter
 - Anything the **physician** does in relation to that patient on same date of service
- Do not include time for another billable service (e.g. 13.99BA) in the calculation of CMX
- **NOTE: No non-physician time (including intern/resident/nursing time) may be included**



Complex Care (April / 10 rates) cont'd

Complex Modifier for Hospital Inpatients (03.03D) (03.03AR)

- COMX – Complex patient care \$38.56
 - Inpatients with multi-system disease
 - Co-morbidities complicate or increase care required
 - Minimum of 20 minutes
 - Not claimable transfer of care
 - One/patient/physician/day
 - Active treatment hospital
 - More than one physician caring for patient each may claim if conditions met



Billing Options (April /10 rates)

- Psychiatric patient seen for 15 minutes
 - 08.19G \$43.63
 - or
 - 03.03A CMGP01 (36.23+15.70) \$51.93

- Palliative care patient seen for 15 minutes
 - 03.05I \$49.51
 - or
 - 03.03A CMGP01 (36.23+15.70) \$51.93



AADAC Admission (April /10 rate)

- 03.04I Comprehensive visit, including completion of form, required for admission to an Alberta Alcohol and Drug Abuse Commission (AADAC) residential treatment facility \$137.13



Capacity Determination

- 03.04N Comprehensive evaluation including completion of forms to determine capacity as defined by the Personal Directives Act (PDA) (*RSA 2007 s9(2)(a)*) \$180.78

NOTE: 1. Benefit includes witnessing the agents' or service providers' assessment.

2. May be claimed to determine lack of capacity or to determine that capacity has been regained.



BMI Modifier

- Pays an additional 25% for
 - BMI of 35 or greater or pediatric greater than 97 percentile
 - Selected procedures, all general anesthetics or regional blocks provided in the OR, day surgery, endoscopy suite or labor and delivery
 - BMISRG
 - Applicable to SA



After Hours Premium Payments

- Outside normal working hours
- Attend on a priority basis
- Special call by staff or another physician
- Direct attendance
- Surcharge modifiers - Procedures, surgical assists, anesthesia, obstetrical deliveries, consultations, detention time
- Callbacks - must have left and been called back to bill a subsequent callback
 - Subsequent patients seen at same callback – refer to GR 5.2.3



After Hours Premium Payments Cont'd

Unscheduled services (Modifier EV, WK, NTAM, NTPM)

- Cover a degree of disruption
- Attend on a priority basis
- Unscheduled
- Special call by staff or another physician
- Start of encounter determines modifier
- Not payable if physician initiates the encounter
- One unscheduled service modifier per encounter
- Direct attendance



After Hours Callbacks (April /10 rates)

Callbacks separated into callback & Visit

- ER/LTC
 - 03.03KA (M-F 0700 – 1700) \$ 71.03
 - 03.03LA (M-F 1700-2200)
(W/E 0700 – 2200) \$ 93.58
 - 03.03MC & 03.03MD (2200 – 0700) \$181.43
 - ER Bill in addition to 03.03A, 03.03B, 03.04A etc
 - LTC bill in addition to 03.03EA
- 03.03EA Visit to LTC in association with
special call back \$28.47



After Hours Callbacks (April /10 rates) cont'd

Callbacks separated into callback & Visit

- In -patient
 - 03.05N (M-F 0700 -1700) \$ 71.03
 - 03.05P (M-F 1700 – 2200) \$ 93.58
 - 03.05R (W/E 0700 – 2200) \$ 93.58
 - 03.05QA & 03.05QB (2200 – 0700) \$181.43

- 03.03DF Visit to inpatient in association with special call back \$33.82



Callback to hospital in patient (April /10 rate) cont'd

- 03.03AR Urgent or priority attendance on hospital in patient or LTC patient when physician on site \$38.78
 - Physician of record or physician working on call rotation
 - May not be claimed by extenders
 - May not be used in calculation of time for COMX



After Hours Premium Payments cont'd

Compensation for time

- 03.01AA After hours time premium /15min
 - No fee associated
 - Payable for scheduled & unscheduled services
 - May be physician initiated
 - Direct patient care time related to the provision of an insured service



After Hours Premium Payments

03.01AA After hours time premium /15min (hospital only)

- Use with modifiers

- TEV (1700 – 2200 W/D) \$21.42/15 min
- TNTA (Midnight – 0700) \$42.84/15 min
- TNTP (2200 – Midnight) \$42.84/15 min
- TST (0700 – 2200 – Stat) \$42.84/15 min
- TWK (0700 – 2200 W/E) \$21.42/15 min
- One patient/15 min
- Bill according to time 15 min period where majority of time spent
- If time covers two time periods bill each modifier
- If time covers two dates of service (2200 – 0400) –need to bill two 03.01AA (one for each date of service)



Billing Example

1. Callback to hospital ER on weekend (15 minutes).

03.03LA + 03.03A + 03.01AA TWK01

2. Second patient same callback – inpatient (30 minutes)

03.03AR + 03.01AA TWK02

3. Callback to in patient Friday evening

03.05P + 03.03DF + 03.01AA



Billing Example - Scheduled

4. Routine LTC rounds after 5PM – 8
patients seen total time with all patients
was 1 hour
03.03E on all 8 patients +
03.01AA TEV01 on 4 patients
5. Surgical assist at C-section 1630 – 1730
weekday
86.9C SA + 03.01AA TEV02



Long Term Care

- 03.03E Periodic chronic care visit
 - 1/week if no other visit precedes same calendar week (Sun – Sat)
 - 03.03K, L, MA & MB + 03.03EA may be claimed subsequent to 03.03E
- Palliative care or intercurrent illness
 - Bill as 03.03D (daily hospital visits)
 - Use date for admission as the first day of intercurrent illness.

LTC



Team/Family Conferences LTC

- 03.05JD Formal, scheduled, multiple health discipline conference /5min \$13.09
 - Patient in continuing care facility
 - Includes - care planning, care plan review, annual integrated care conference, patient management



Medication Review

- 03.05JE Formal scheduled review of patient medication (multiple patients) \$27.79
 - Patient in continuing care facility
 - Most responsible physician
 - Max of 6 patients/30 min
 - Text naming personnel and agencies involved
 - Claimable with other services on SDOS
- 03.05JF Second physician at medication review (multiple patients) \$22.74



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