

mcp newsletter

September 29, 2026

26-05

TO: ALL PHYSICIANS

RE: NEW MCP PAYMENT SCHEDULE EFFECTIVE OCTOBER 1, 2026

The Department of Health and Community Services and the Newfoundland and Labrador Medical Association (NLMA) have completed allocating funds negotiated under the 2017-23 Memorandum of Agreement (MOA) for increases to fee-for-service compensation. As a result, a new MCP Medical Payment Schedule will come into effect on October 1, 2026 at 00:00. This new Payment Schedule will apply to physician services insured by MCP rendered on or after this date and time. If you are not a fee-for-service physician, this newsletter is provided for information only.

Given that funds awarded from the 2017-23 microallocations process are now incorporated into the Payment Schedule, the biweekly across-the-board (ATB) increases from the 2017-23 MOA will discontinue with the publication of this Payment Schedule. However, biweekly ATB increases will continue to apply for the 2023-27 MOA. For updated rates reflecting publication of the new Payment Schedule and the continuation of 2023-27 ATB biweekly adjustments, please see newsletter [26-06](#). The ATB percentage increases from the 2023-27 MOA will be applied automatically to the rates in the new Payment Schedule.

Physicians should continue to bill for services using the current rates and conditions as listed in the 2019 Payment Schedule until 00:00 October 1, 2026 to avoid claim rejection. The amount claimed will be increased by biweekly adjustments which include the 2017-23 MOA increases until that time. Claims for services rendered on or before 23:59 on September 30, 2026 should continue to be billed using the 2019 Medical Payment Schedule if the claim for those services is submitted after that date and time.

All physicians are advised to review the new Payment Schedule and to familiarize themselves and their billing staff with those sections, especially Preamble sections, which are relevant to their own practice. For ease of identification, changes to the Payment Schedule have been printed in bold. Given the introduction of this Payment Schedule with concurrent changes made as a result of the 2023-27 MOA, bolded changes may reflect the 2017-23 or 2023-27 MOA. The microallocations process for the 2023-27 MOA has

not yet started. A revised Payment Schedule will be published once the 2023-27 microallocations process is complete.

The new Payment Schedule is posted on [Information for Medical Care Plan \(MCP\) Providers - Health and Community Services](#). The 2019 Payment Schedule will also remain posted temporarily for reference and for any claims with service dates prior to 00:00 October 1, 2026. Please make sure that you are using the correct Payment Schedule when submitting claims to MCP. This will help avoid rejected claims.

Questions related to the new Payment Schedule may be directed to the Claims Department at 1-800-440-4405 or the Assistant Medical Director at AssistantMedicalDirector@gov.nl.ca or (709) 758-1557.

KEY FEATURES OF THE NEW SCHEDULE

Changes to language and rates are printed in bold type. Changes are specific to specialty, with the exception of “general changes” which apply to more than one physician group. Not all specialties were awarded funding in the 2017-23 MOA. As a result, those specialties are not listed below.

General Changes:

- Increases from the 2017-23 MOA implemented in 2022 (see [MCP newsletter 22-08](#)):
 - o Sessional clinics increased to \$566.53 for family physicians and \$659.26 for consultants
 - o Surgical Assist rates for dedicated time and time and basic rates
 - o On-call rates
 - o External locum rates
 - o Internal locum hourly rates
 - o Long-Term Care per diem/bed rates
 - o Category A and B hourly rates
 - o Special Visit Premiums for family physicians and consultants
- Increases from the 2023-27 MOA implemented in 2025 (see newsletters [25-15](#), [25-17](#), and [25-18](#)) also apply to the following rates: surgical assist, on-call, internal and external locum, Category A, long-term care per diem, and special visit premiums. Please see MCP newsletter [26-06](#) for rates that become effective October 1, 2026. Rates in the new Payment Schedule reflect the most recent changes.

- The interim rate structure for Category B set out in [MCP newsletter 26-04](#) will remain in place until implementation of a new payment model.
- Following the settlement of a legal case with the NLMA in May 2023, fee codes for specific assessment and specific reassessment have been removed from the new Payment Schedule. For all specialties except Family Medicine, fee codes for general assessment and general reassessment have also been removed. These codes have been replaced by a new visit fee code called “Assessment” (see fee codes 115, 215, 315, and 415) for consultant physicians. If specialists bill any of the expired codes (i.e. general assessments, general reassessments, or specific assessments), those codes will be rejected.
- Critical Care: ICU and CCU fee code increases.
- Virtual care should continue to be billed as per MCP newsletters [20-09](#) (consultants) and [20-10](#) (family physicians) until new permanent fee codes are implemented.
- The remaining specialty corrections fund has been allocated as part of this MCP Payment Schedule.

Changes By Specialty:

Family Medicine

- Increased rates for select Consultations and Visits
- New fee code for Prenatal Care Subsequent Assessment (fee code 119). See Payment Schedule for details.
- Fee code 54598 (“Ear syringing”) has been renamed “Ear wax removal”. The rate has also increased.
- Rate increase for fee code 54614 (“Speculum exam”)
- Caps for Family Medicine Counselling fee code 129 increased from 125 to **200** units per family physician per year

Anaesthesiology

- Increases to Pain clinic consultations and reassessments (fee codes 400 and 419)
- Rate increases to select Nerve Blocks fee codes
- Fee code 54162 (“Maintenance of sustained regional nerve block”) increased from 3 hours to a maximum of 6 hours per day
- Rate increases to Hyperbaric Oxygen Therapy fee codes 54180 to 54192, 54198 and 54199
- Increased rate for fee code 54377 (“Transoesophageal echocardiography”)
- Basic fee code rates and time units increased to \$18.80 per unit
- New fee code 90027 Special Procedures: Anaesthesiology additional fee for adults 80 years or older. As a result, the description for fee code 90026 has changed to “Anaesthesiology additional fee for adults 70 **to 79**”.
- Increased units for Special Procedures fee codes 90028 and 90042

General Surgery

- Rate increases for Consultations and Subsequent Visits
- Increases to the following Diagnostic and Therapeutic Services:
 - o 54220 (“Insertion of permanent feeding line under general anaesthesia”)
 - o Hospital Vascular Laboratory fee codes 54425 to 54427
 - o Insertion and Removal of peritoneal cannula or catheter (54486 and 54487)
 - o Varicose vein injection fee codes 54710 and 54712
- Increases to the following Surgical Procedures fee code rates:
 - o Operations on the Integumentary System
 - select Incision fee codes
 - select Excision of Benign Lesions (Group 4) fee codes
 - select Repair: Myocutaneous flaps and Split Thickness Grafts fee codes
 - o Operations on the Breast: select Incision and Excision fee codes
 - o Operations on the Musculoskeletal System:
 - Hand and Wrist: Biopsy, Excision – Muscle and Tendon fee codes
 - Elbow and Forearm: Biopsy, Excision – Bursae fee codes
 - Femur: Amputation, Excision – Muscle fee codes
 - o Operations on the Respiratory System: Lungs and Pleura: select fee codes
 - o Operations on the Cardiovascular System:
 - select fee codes under Arteries and Veins
 - o Operations on the Haemic and Lymphatic System: Splenectomy fee code 95370

- o Operations on the Digestive System
 - Oesophagus: select fee codes
 - Stomach: select fee codes
 - Intestines: select fee codes
 - Appendix: all fee codes
 - Rectum: select fee codes
 - Anus: select fee codes
 - Liver: select fee codes
 - Biliary Tract: all fee codes
 - Pancreas: select fee codes
 - Linear or Radial Echo-Endoscope (Endoscopic Ultrasound): all fee codes
 - Abdomen, Peritoneum and Omentum: select fee codes
- o Operations on the Endocrine System: select Parathyroid, Thymus and Adrenal Glands fee codes
- o Operations on the Nervous System: Temporal artery – biopsy, ligation, or cryosurgery fee code 98372
- o Operations on the Ear: Excision: Amputation fee codes 99338 and 99340

Internal Medicine

- Rate increases to select Consultations and Visits
- Rate increases to select Diagnostic and Therapeutic Services:
 - o select Cardiovascular fee codes
 - o select Dialysis fee codes
 - o select Gastroenterology fee codes
 - o all Chemotherapy fee codes
- Rate increases to select fee codes in Clinical Procedures Associated with Diagnostic Radiological Examinations
- Rate increases to In-Hospital Diagnostic and Therapeutic Services:
 - o select Electrocardiograms fee codes
 - o all Sleep Apnea Studies fee codes
 - o select Pulmonary Function Studies fee codes
- Rate increases for Surgical Procedures:
 - o Operations on the Respiratory System:
 - Trachea and Bronchi: Endoscopy: select Bronchoscopy fee codes
 - Lungs and Pleura: Introduction – Thoracentesis fee codes 94660 and 94662
 - o Operations on the Cardiovascular System: all General Fees fee codes

- o Operations on the Haemic and Lymphatic System: select Spleen and Marrow fee codes
- o Operations on the Digestive System:
 - select Oesophagus fee codes
 - select Intestines fee codes:
 - Endoscopy
 - Endoscopic retrograde cholangiopancreatography
 - Colonoscopy
 - Paracentesis fee codes 96620, 96622, and 96626 (under Abdomen, Peritoneum and Omentum)

Neurology

- Rate increases to select Consultations and Visits
- Rate increases to Diagnostic and Therapeutic Services:
 - o Fee code 54030 (“Repository therapy”)
 - o Injection fee codes for Botulinum Toxin 54652, 54654
 - o Injection fee code 54656
- Rate increases to In-Hospital Diagnostic and Therapeutic Services:
 - o all Electromyography and Nerve Conduction fee codes
 - o all Electroencephalography fee codes
 - o Evoked Potential Studies fee code 57500

Obstetrics/Gynecology

- Rate increases for select Consultations and Visits
- Rate increases for In-Hospital Diagnostic and Therapeutic Services: Obstetrics and Gynecology: Maternal Fetal Medicine fee codes 57710 to 57717

Ophthalmology

- Increases to select Consultations and Visits
- Two new fee codes:
 - o an add-on fee code for pediatric visits (fee codes 120 and 420)
 - o a new fee code for Cyclophotocoagulation (98903)

Please see the Payment Schedule for details on these two new fee codes.
- Increases to select fee codes in the Diagnostic and Therapeutic Services: Ophthalmology section
- Increases to select fee codes in the Surgical Procedures: Operations on Organs of Special Senses: Operations on the Eye section

Orthopaedic Surgery

- Increases to select Consultations and Visits
- Increases to select fee code rates in Surgical Procedures: Operations on the Musculoskeletal System in all sections except “Skull and Mandible”
- Increased rate for Operations on the Cardiovascular System
 - o Arteries fee code 95058 (“Exploration of Major Artery”)
 - o Veins: Ligation fee code 95250 (“Saphenous”)

Otolaryngology

- Increases to select Consultations and Visits
- Increases to the following fee code rates in Diagnostic and Therapeutic Services:
 - o 54900 (“Particle repositioning manoeuvre for benign paroxysmal positional vertigo”)
 - o 54910 (“Pure tone and bone conduction: professional component with speech tests”)
- Increases to fee code rates in Surgical Procedures
 - o Operations on the Respiratory System:
 - Accessory Nasal Sinuses fee code Maxillary: maxillectomy (fee code 94384)
 - Trachea and Bronchi:
 - Endoscopy: Triendoscopy fee code 94524
 - Incision: “Tracheostomy” fee code 94532
 - o Operations on the Haemic and Lymphatic System:
 - Lymph Nodes: Excision: Biopsy fee codes 95426, 95428, and 95430
 - o Operations on the Digestive System:
 - Mouth: Excision fee codes 95460 and 95468
 - Pharynx, Adenoids and Tonsils Incision fee codes and select Excision fee codes
 - o Operations on Organs of Special Senses: Operations on the Ear
 - Middle Ear: Repair fee code 99430 (“Myringoplasty”)
 - Inner Ear: Permanent Cochlear Prosthesis Insertion: Intra-cochlear fee code 99502
- Increase to 644070 Otolaryngology Cancer Clinic: \$1,800.50 per clinic plus applicable ATB increases from the 2023-27 MOA. For the rate for October 1st, please see newsletter [26-06](#): Alternate Billing System (ABS) Rate Changes.
- New fee code 98023 “Completion thyroidectomy following previous subtotal or hemi-thyroidectomy”.

- Two expired fee codes:
 - o 98026 (“Hemi-thyroidectomy”)
 - o 94530 (“Emergency Tracheostomy”)
- Revised definition, verbiage changes and/or assessing rules:
 - o Fee code 94532 (“Tracheostomy”) should now be used for all tracheostomies whether they are emergency or elective procedures. Fee code 94530 has been expired.
 - o Fee code 94454 (“laser with microlaryngoscopy”) is now also eligible for billing for **malignant** disease as an add-on to 94444 (“Direct laryngoscopy with removal of lesion(s)” or **94446** (“Direct laryngoscopy with dilation of larynx and bronchoscopy”).

Plastic Surgery

- Increases to all Consultations and Visits
- Increases to fee code rates in Surgical Procedures:
 - o Operations on the Integumentary System:
 - Repair
 - (Simple) muscle repair fee code 90330
 - all Tissue Expanders fee codes
 - Skin Grafts
 - o Full thickness Grafts fee codes
 - o Free Island Flaps: Bone Flaps
 - Destruction fee code 90584 (“Rhinopyoma”)
 - Increases to Webbed Fingers and Webbed Toes fee codes 90590 and 90596
 - Burns fee codes
 - o Operations on the Breast: select Repair fee codes
 - o Operations on the Musculoskeletal System:
 - General Fees
 - Fixation fee code 90836 (“Percutaneous pinning”) and 90840, 90842 (“Removal of internal device”) fee codes
 - Wound Care fee code 90866 (“Excision of foreign body”)
 - Hand and Wrist
 - all Amputation fee codes
 - all Arthroplasty fee codes
 - Arthrotomy fee codes 91040 and 91042
 - Exploration and/or decompression and/or transposition and/or neurolysis of major nerve fee code 91072
 - all Incision and Drainage fee codes

- Manipulation fee code 91100
- Excision – Bone fee codes and Muscle fee codes 91150 and 91152
- all Reconstruction – Bone fee codes
- Reconstruction – Tendon repair – flexor- single fee codes
- Reconstruction – Extremities fee codes
- all Release – Tendon fee codes
- select fee codes in Reduction – Fractures
- Shoulder/Arm/Chest
 - Sternum Reduction – Fractures fee codes 91996 (“closed reduction”) and 92001 (“extensive debridement of compound fracture”)
- Skull and Mandible
 - all Biopsy fee codes
 - Incision and Drainage fee code Mandibular sequestrectomy 92060
 - Orthognathic Surgery fee code 92266 (“Removal intermaxillary fixation devices”)
 - select fee codes for Reduction – Fractures (Orbit, Mandible, Maxilla, and Temporo-mandibular joint)
- o Operations on the Digestive System
 - Lips: Reconstruction fee codes
 - Palate and Uvula: Repair fee codes 95590 and 95594
 - Closure of fistula fee codes 95600 and 95602
- o Operations on the Nervous System: select Peripheral Nerves fee codes
- o Operations on Organs of Special Senses: Operations on the Ear: External Ear: select Repair fee codes
- Changes to adjudication of DIEP flaps:

For post-mastectomy DIEP flaps only, fee code 90720 (“Breast mound creation by prosthesis and/or soft tissue”) is now billable with one or any combination of Free Island Flaps fee codes 90490, 90492, 90494. The operative report must document creation of the breast mound as well as the applicable free island flap codes (90490, 90492, 90494).

Psychiatry

- Increases to select Consultations and Visits
- Increase to fee code 54990 “ECT”
- Two new fee codes:
 - o 143/243/343/443: Diagnostic or therapeutic interview with substitute decision maker of an adult patient. Please see Payment Schedule for details.
 - o 183/483: Opioid Agonist Therapy for Opioid Use Disorder. Please see Payment Schedule for details.
- The formatting of “Psychiatric Care” in the Consultations and Visits section has changed to improve clarity and to better align with the General Preamble.

Urology

- Increases to Consultations fee codes
- Increased rate to fee code 54518 (“Implantation of Hormone Pellets”)
- Increased rate to fee code 55120 (“Urethrocystogram”)
- Increases to Surgical Procedures:
 - o Operations on the Haemic and Lymphatic System fee code 95438 (“Staging pelvic lymphadenectomy”)
 - o Operations on the Urogenital System:
 - Kidneys and Perinephrum
 - Percutaneous Procedures: Removal of renal calculi (fee code 96812)
 - Excision: Nephrectomy fee codes 96865 and 96868
 - Repair fee code 96880 (“Pyeloplasty”)
 - Extracorporeal Shock Wave Lithotripsy fee codes 96918 and 96920
 - Bladder
 - select Endoscopy-Cystoscopy fee codes
 - Excision fee code 97160 (“Cystectomy with uretero-ileal conduit”)
 - Urethra
 - Incision fee code 97290 (Meatotomy and plastic repair”)
 - Endoscopy fee code 97324 (“Internal urethrotomy”)
 - Repair fee code 97342 (“One stage repair”)
 - Destruction fee code 97380 (“Urethro-vesicolysis”)
 - Manipulation fee code 97390 (“Dilation of stricture, male under local anaesthetic”)

- Penis
 - Incision fee code 97414 (“Slit of prepuce: adult”)
 - select Excision fee codes
 - Repair: Hypospadias or Epispadias fee code 97448 (“Plastic reconstruction, urethra”)
- Testis: Incision fee codes 97481 (“Retroperitoneal lymph node dissection post-chemotherapy”) and 97482 (“Radical orchidectomy for malignancy – unilateral”)
- Spermatic Cord: Excision: Hydrocele fee code 97590
- Prostate: Endoscopy fee codes 97640 (“Transurethral electrosection”) and 97641 (“Laser photovaporization”)

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