

Medical Payment Schedule



Medical Care Plan
Department of Health & Community
Services

October 1, 2019

TABLE OF CONTENTS

PAGE	CONTENTS
A-1	Payment Schedule Identification Changes, etc. to the Payment Schedule Effective Date of Listed Services NLMA Involvement
A-1 – A-4	Payment Schedule Layout with descriptions of each section of the Schedule as follows: Listing of the Sections General Preamble Appendices Visit Premiums Consultations and Visits Telemedicine Critical Care Diagnostic and Therapeutic Services In-Hospital Diagnostic and Therapeutic Services Radiology Nuclear Medicine Obstetrics Anaesthesia for Surgical-Dental Procedures Surgical Procedures Tables
A-5 – A-6	Insured/Non-Insured Services, with divisions as follows: Insured Services Non-Insured Services Common Elements of Insured Services
A-7 – A-9	Claim Submission Rules Documentation Requirements Minimum Required Documentation for Claims Independent Consideration Submission Provider Billing Number Time Limitations on Claim Submission
A-10 – A-13	Definitions of Terms/Conditions
A-10 – A-11	Site of Insured Service, with some rules regarding each, as follows: Office Home Hospital In-Patient Hospital Out-Patient and Emergency Department Visits to Other Sites
A-11 – A-12	Delegated Procedures Age (of Patients) Defined Most Responsible Physician Defined Referral and Transferral Defined
A-12	Rules re Transferrals
A-13	Team Care in Teaching Units

TABLE OF CONTENTS

PAGE	CONTENTS
A14 – A-18	Consultations
A-14	Consultations Defined
A-14	Documentation of Consultations
A-14 – A-15	Rules Applicable to Consultations
A-15 – A-18	Major Consultations – Defined and with rules specific to each
A-19 – A-34	Definitions and Rules for each visit type, other than consultations, listed in alphabetical order of first letter of the visit name as listed in the Visits Section.
A-35 – A37	Critical Care Section of the Schedule described, giving the rules for billing from it.
A-38 – A40	Diagnostic and Therapeutic Procedures Section of the Schedule described, giving the rules for billing from it.
A-41	In-Hospital Diagnostic Procedures Section of the Schedule described, giving the rules for billing from it.
A-42 – A-44	Radiology Section of the Schedule described, giving the rules for billing from it.
A-45	Nuclear Medicine Section of the Schedule described, giving the rules for billing from it.
A-42 – A-57	Specific Rules for Billing
A-42 – A-45	Radiology/Nuclear Medicine Services
A-46	Obstetric Services
A-47 – A-49	Surgical Procedures, generally
A-50 – A-51	Fracture Care
A-52	Surgical Assist – Standard Method
A-52 – A-53	Surgical Assist – Dedicated Time Method
A-53	Specialist Assistant
A-54 – A-57	Anaesthesiology Services
A-58 – A-60	Premiums
A-58 – A-60	General Rules for Billings Premiums, Both Visit and Procedure
A-58 – A-59	Specific Rules for Billing Visit Premiums
A-59 – A-60	Specific Rules for Billing Procedure Premiums
A-60	Specific Rules for Billing Delivery Premiums
A-61 – A-62	Specific Rules for Billing Sessional Arrangements, listed as follows:
A-61 – A-62	General Policy for all Sessional Arrangements
A-61 – A-62	Rules Specific to Organized Sessional Clinics and Institutional Care
A-62	Rules Specific to On-Site Emergency Department Coverage –Category Facilities
A-62	Rules Specific to Dedicated On-Site 24-Hour ICU Sessional Coverage
A-63	Specific Rules for Billing for Emergency Department Coverage by Family Physicians – Category ‘B’ Facilities
A-64	Specific Rules for Billing Long Term Care Facility Coverage by Family Physicians
A-65 – A-66	Rural Family Physician Hospital Premium
A-67	Physician Registration
A-67	Locum Coverage

TABLE OF CONTENTS

PAGE	CONTENTS
A-68	Appendix A – Category ‘A’ Approved Facilities for 24-Hour On-Site Emergency Department Coverage
A-69	Appendix B – Category ‘B’ Approved Facilities for 24-Hour Emergency Department Coverage
A-70 – A-71	Appendix C – HCS Designated Long Term Care Facilities with Long Term Beds
A-72 – A-73	Appendix D – Immunization of Designated Target Populations
A-74	Appendix E – Non-Insured Services List
A-75	Appendix F – Scar Revision
A-76	Appendix G – Hyperbaric Oxygen Therapy
B-1 – B-2	Visit Premiums Listing
B-1	Office
B-1	Home
B-1	Hospital In-Patient
B-2	Hospital Out-Patient and Emergency
C-1 – C-30	Visit Listings by Specialty, beginning with Family Medicine ,
C-1 – C-5	Family Medicine
C-6	Anaesthesiology
C-7	Dermatology
C-8	Emergency Medicine Specialist
C-9	General, Cardiac, Vascular or Thoracic Surgery
C-10	Internal Medicine
C-11	Nuclear Medicine Specialist
C-12	Developmental Neurology
C-13	Neurology (except Developmental Neurology)
C-14	Neurosurgery
C-15	Obstetrics and Gynecology and Gynecological Oncology
C-16 – C-17	Ophthalmology
C-18	Orthopaedic Surgery
C-19	Otolaryngology
C-20 – C-21	Paediatrics (except Developmental Paediatrics)
C-22 – C-23	Developmental Paediatrics
C-24	Physical Medicine
C-25	Plastic Surgery
C-26 – C-28	Psychiatry
C-29	Urology
C-30	Radiology
C-31	Telemedicine Preamble
C-31	General Policy
C-31	Terms and Conditions
C-32 – C-49	Telemedicine Consultations and Reassessments
C-32	Family Medicine
C-33	Dermatology

TABLE OF CONTENTS

PAGE	CONTENTS
C-34	General Surgery
C-35	Internal Medicine
C-36	Nuclear Medicine
C-37	Developmental Neurology
C-38	Neurology
C-39	Neurosurgery
C-40	Obstetrics and Gynecology
C-41	Ophthalmology
C-42	Orthopaedics
C-43	Otolaryngology
C-44	Paediatrics
C-45	Developmental Paediatrics
C-46	Physical Medicine
C-47	Plastic Surgery
C-48	Psychiatry
C-49	Urology
C-50 – C-52	Appendix H – Approved Telemedicine Sites
D-1 – D-3	Critical Care Listing
D-1	Neonatal Intensive Care
D-2	ICU and CCU
D-3	Cardio-Pulmonary Resuscitation
D-3	Provincial Perinatal High Risk Unit
E-1 – E-23	Diagnostic and Therapeutic Services Listings
E-1	Allergy
E2 – E-3	Anaesthesiology/Therapeutic
E-4	Hyperbaric Oxygen Therapy
E-5 – E-9	Cardiovascular
E-10	Dermatology
E-11	Dialysis
E-12	Endocrinology and Metabolism
E-12	Gastroenterology
E-13	Family Medicine
E-13	Gynecology
E-14 – E-16	Injections or Infusions
E-17	Neurology
E-17 – E-19	Ophthalmology
E-20	Otolaryngology
E-21	Physical Medicine
E-22	Psychiatry
E-22	Urology
E-22	Venipuncture
E-23	Clinical Procedures Associated with Diagnostic Radiological Examinations
F-1 – F-7	In-Hospital Diagnostic and Therapeutic Services Listings
F-1	Electrocardiograms
F-1	Electromyography and Nerve Conduction
F-1	Electroencephalography
F-1	Sleep Apnea Studies
F-2	Evoked Potential Studies

TABLE OF CONTENTS

PAGE	CONTENTS
F-2	Dermatology
F-3 – F-4	Obstetrics and Gynecology
F-4	Ophthalmology
F-5	Organized Pain Clinic
F-5	Otolaryngology
F-6 – F-7	Pulmonary Function Studies
G-1 – G-18	Radiology Services Listings
G-1 – G-3	General Radiology
G-4 – G-7	Special Procedures
G-8	Other Items
G-9 – G-13	Diagnostic Ultrasound
G-13	Therapeutic Ultrasound
G-14 – G-16	Computed Tomography
G-17	Magnetic Resonance Imaging
G-18	Interventional Radiology
H-1 – H-4	Nuclear Medicine Services Listings
H-1	Cardiovascular System
H-1	Endocrine System
H-1 – H-2	Gastrointestinal System
H-2	Genitourinary System
H-2	Hematopoietic System
H-3	Musculoskeletal System
H-3	Nervous System
H-3	Respiratory System
H-3	Miscellaneous
H-3	SPECT – Single Photon Emission Computerized Tomography
H-3	Special Visit Premiums
H-4	Therapy using Radioisotopes
I-1 – I-4	Obstetrics Services Listings
I-1	Obstetrical Care
I-2	Anaesthesiology
I-3	Operative Delivery
I-4	Surgical Obstetrics
J-1 – J-9	Anaesthesia for Surgical Dental Procedures
J-1	Extractions
J-1	Extraction of Impacted Teeth
J-1	Surgical Exposure of Teeth
J-1	Surgical Movement of Teeth
J-1 – J-2	Remodelling and Recontouring Oral Tissues
J-2	Test, Histological
J-2 – J-3	Surgical Excisions
J-3	Surgical Incisions
J-4	Treatment of Fractures
J-5 – J-6	Treatment of Maxillofacial Deformities

TABLE OF CONTENTS

PAGE	CONTENTS
J-6 – J-7	Treatment of Temporomandibular Joint Dysfunctions
J-7	Treatment of Salivary Glands
J-7 – J-8	Neurological Disturbances
J-8	Antral Surgery
J-8	Haemorrhage Control
J-8	Grafts, Surgical
J-8	Emergency Procedures
J-9	Special Procedures
K-1 – K5	Surgical Procedures
K-1	Surgical Premiums Listing and some description
K-2 – K-4	Surgical Premiums – Morbidly Obese Patients
K-5	Special Procedures Listing
L-1 – L-11	Operations on the Integumentary System
L-1	Incision
L-2 – L-4	Excision
L-2 – L-3	Excision of Benign Lesions
L-4	Excision of Malignant and Premalignant Lesions
L-4 – L-9	Repair
L-10	Plastic Surgery Procedures
L-11	Operations on the Breast
M-1 – M-40	Operations on the Musculoskeletal System
M-1 – M-2	General Fees
M-3 – M-8	Hand and Wrist
M-9 – M-12	Elbow and Forearm
M-13 – M-16	Shoulder/Arm/Chest
M-17 – M-21	Skull and Mandible
M-22 – M-25	Spine
M-26 – M-28	Pelvis and Hip
M-29 – M-30	Femur
M-31 – M-33	Knee
M-34 – M-35	Fibula and Tibia
M-36 – M-40	Foot and Ankle
N-1 – N-7	Operations on the Respiratory System
N-1 – N-2	Nose
N-2 – N-3	Accessory Nasal Sinuses
N-3	Larynx
N-4	Trachea and Bronchi
N-5	Chest Wall and Mediastinum
N-6 – N-7	Lungs and Pleura
O-1 – O-7	Operations on the Cardiovascular System
O-1	General Fees
O-1 – O-3	Heart and Pericardium
O-3 – O-6	Arteries
O-6 – O-7	Veins

TABLE OF CONTENTS

PAGE	CONTENTS
P-1	Operations on the Haemic and Lymphatic System
P-1	Spleen and Marrow
P-1	Lymph Channels
P-1	Lymph Nodes
Q-1 – Q-16	Operations on the Digestive System
Q-1	Mouth
Q-1	Lips
Q-2	Tongue
Q-2	Teeth and Gums
Q-2	Palate and Uvula
Q-3	Salivary Glands and Ducts
Q-3 – Q-4	Pharynx, Adenoids and Tonsils
Q-4 – Q-5	Oesophagus
Q-5 – Q-6	Stomach
Q-7 – Q-9	Intestines (except Rectum)
Q-9	Meckel's Diverticulum and the Mesentery
Q-9	Appendix
Q-9 – Q-10	Rectum
Q-11	Anus
Q-12	Liver
Q-13	Biliary Tract
Q-14	Pancreas
Q-15 – Q-16	Abdomen, Peritoneum and Omentum
R-1 – R-7	Operations on the Urogenital System
R-1 – R-2	Kidneys and Perinephrum
R-3	Ureter
R-4 – R-5	Bladder
R-6 – R-7	Urethra
S-1 – S-4	Operations on the Male Genital System
S-1	Penis
S-2	Testis
S-2	Epididymis
S-2	Tunica Vaginalis
S-3	Scrotum
S-3	Vas Deferens
S-3	Spermatic Cord
S-3	Seminal Vesicles
S-4	Prostate
T-1 – T-5	Operations on the Female Genital System
T-1	Vulva
T-2	Vagina
T-3	Fallopian Tube
T-3	Ovary
T-3 – T-5	Uterus and Cervix Uteri

TABLE OF CONTENTS

PAGE	CONTENTS
U-1	Operations on the Endocrine System
U-1	Thyroid Gland
U-1	Parathyroid, Thymus and Adrenal Glands
V-1 – V-7	Operations on the Nervous System
V-1 – V-3	Brain
V-3	Skull
V-4	Orbit
V-4	Pituitary
V-4	Carotid and Vertebral Arteries
V-4	CSF Shunting Procedures
V-4 – V-5	Cranial Nerves
V-5	Peripheral Nerves
V-6	Autonomic Nervous System
V-6 – V-7	Spinal Cord and Nerve Roots
W-1 – W-9	Operations on Organs of Special Senses
W-1 – W-6	Eye
W-1	Eyeball
W-1 – W-2	Cornea
W-2	Sclera
W-2	Iris and Ciliary Body
W-2	Crystalline Lens
W-3	Vitreous
W-3	Retina
W-3	Extraocular Muscles
W-4	Orbit
W-4 – W-5	Eyelids
W-6	Conjunctiva
W-6	Lacrimal Tract
W-7 – W-9	Ear
W-7	External Ear
W-8	Middle Ear
W-9	Inner Ear
W-9	Acoustic Nerve
X-1 – X-9	Tables
X-1	I – Anaesthesia Basic Fee Code Rates
X-2	II – Anaesthetic Time Units – Surgical Procedures
X-3	III – Epidural Anaesthesia for Pain Control
X-4	IV – SHVs – Type 2
X-5 – X-7	V – SHVs – Type 3 and Type 4
X-8	VI – Surgical Assistants Time Units – Standard Method
X-9	VII – Surgical Assistants Time Units – Dedicated Time Method

GENERAL PREAMBLE

1. This Payment Schedule identifies the amounts prescribed as payable and rules and conditions of payment under the Physicians and Fee Regulations (Schedule A), governed by the Medical Care Insurance Act for insured services rendered by licensed physicians. The items and fees listed apply to services rendered on and after the “effective date” at the top of each page.

The amounts published in Payment Schedule are subject to existing payment policies authorized by the Medical Care Plan (MCP).

Additions, deletions and changes to be made to the Payment Schedule require recommendation by MCP and approval by the Minister of Health and Community Services, in consultation with the Newfoundland and Labrador Medical Association (NLMA).

Any changes made during the effective life of the Payment Schedule are published in MCP Newsletters when necessary. It is the responsibility of claiming physicians to ensure these changes are reflected in their billings.

GENERAL PREAMBLE

2. INTRODUCTION

The Payment Schedule is divided into a number of sections:

- General Preamble
- Appendices
- Visit Premiums
- Consultations and Visits
- Telemedicine
- Critical Care
- Diagnostic and Therapeutic Services
- In-Hospital Diagnostic and Therapeutic Services
- Radiology
- Nuclear Medicine
- Obstetrics
- Anaesthesia for Surgical-Dental Procedures
- Surgical Procedures
- Tables

2.1 General Preamble

This section sets out the general definitions and constituent elements common to all insured services, as well as the specific elements for these services.

2.2 Appendices

This section gives listings referred to within the Preamble. These are:

- Approved Category “A” Facilities – 24-Hour On-Site Emergency Department Coverage
- Approved Category “B” Facilities – Emergency Department Coverage
- **HCS** Designated Long Term Care Facilities With Long Term Beds
- Immunization of Designated Target Population
- Non-Insured Services List
- Scar Revision
- Hyperbaric Oxygen Therapy

2.3 Visit Premiums

This section lists the rates and conditions for the billing of premium fees associated with special visits.

GENERAL PREAMBLE

2.4.1 Consultations and Visits

- (a) Visit codes are listed for each of the specialties, beginning with **Family Medicine** followed by a listing for each of the recognized specialty groups. One letter, usually the first letter in each visit code title, is underlined and printed in boldface type, and this letter corresponds to the first letter in the title of the definition/description of the service contained in Section 7 of the Preamble, which is an alphabetical listing.
- (b) For specialty groups, rates are listed for referred patients. Specialists treating “walk-in” or “non-referred” patients should bill for services rendered to such patients using the rates for comparable services as listed in the **Family Medicine** Section.
- (c) Each Consultation and Visit Section is divided into sub-sections based on the site where the insured service is rendered. Namely:
- Office (or visit to Physician’s Residence)
 - Home
 - **HCS** Designated Long Term Care Facilities with Long Term Beds
 - Hospital In-Patient
 - Hospital Out-Patient and Emergency
 - Physician on Duty at Designated 24-Hour On-Site Emergency Department (see Appendix “A”)
 - Hospital Pain Clinic

These sites of insured service delivery are defined and described in the subsequent Definitions of Terms/Conditions Section in this Preamble.

2.4.2 Telemedicine

This section of the Schedule describes the terms and conditions for billing Telemedicine consultations and reassessments, and lists the fees and approved Telemedicine sites.

2.5 Critical Care

This section of the Schedule lists the fees for CPR and the per diem fee payable to the physician-in-charge for ICU/CCU/NICU Care, and for care in the Provincial Perinatal Care Unit.

2.6 Diagnostic and Therapeutic Services

Fees for miscellaneous diagnostic, therapeutic and surgical services are listed in this section.

2.7 In-Hospital Diagnostic and Therapeutic Services

Fees for specific diagnostic and therapeutic services performed in hospital are listed in this section.

GENERAL PREAMBLE

2.8 Radiology

This section of the Schedule lists fees and describes conditions for billing of Diagnostic Imaging Services except Nuclear Medicine Services.

2.9 Nuclear Medicine

This section of the Schedule lists fees and describes conditions for the billing of Nuclear Medicine Services.

2.10 Obstetrics

This section of the Schedule is designed for the billing of services related to pregnancy and delivery. Other related services may be found in the Surgical Procedures Section.

2.11 Anaesthesia for Surgical-Dental Procedures

This section of the Schedule lists fees payable for anaesthesia services for surgical-dental procedures.

2.12 Surgical Procedures

The surgical procedures are listed by anatomical system. Under each system the procedures carried out within the system have been grouped under such sub-headings as Incision, Excision, Suture, Repair, etc. Each procedure listed may be located through determination of the anatomical system to which it applies, and the type of procedure performed. This method of listing has no relationship to the specialty which may be engaged in surgery upon this particular system.

Fees for Surgical Assistants, **Family Physicians**, Specialists and Anaesthesiologists may be listed for each procedure. Where no fee is listed for Assistants or Anaesthesiologists, the service must be billed Independent Consideration (IC).

2.13 Tables

Tables are given for convenience when billing:

- I - Anaesthesia Basic Fee Code Rates
- II - Anaesthetic Time Units – Surgical Procedures
- III - Epidural Anaesthesia for Pain Control
- IV - SHV – Subsequent Hospital Visits – Type 2
- V - SHV – Subsequent Hospital Visits – Types 3 and 4
- VI - Units Table for Surgical Assistants – Billing According to Standard Method
- VII - Units Table for **FP** Surgical Assistants – Billing According to Dedicated Time Method

GENERAL PREAMBLE

3. INSURED/NON-INSURED SERVICES**3.1 Insured Services**

An insured service is defined as one that is:

- (a) listed in Section 3 of the Medical Care Insurance Insured Services Regulations;
- (b) medically necessary. In a medical audit context, the clinical need of the provision and claim of an insured service may be evaluated by the Medical Consultants' Committee of MCP;

Queries as to the insurability of a specific service should be directed to the Office of the Assistant Director of Medical Services. Regulations with respect to insurability of scar revision are listed in Appendix F.

3.2 Non-Insured Services

The following situations/conditions qualify as non-insured services:

- (a) specific services as listed in Section 4 of the Medical Care Insurance Insured Services Regulations or Appendix E of this Preamble,

Queries as to the insurability of a specific service should be directed to the Office of the Assistant Director of **Medical Services**,

- (b) services not included in the Preamble Section that describes Common Elements of an Insured Service,
- (c) any medical services provided at the request of a third party, or which are covered by other agencies,
- (d) medical services provided to patients not insured by MCP or any other provincial Health Care Plan,
- (e) services provided as a result of physician solicitation,

Services which are reviewed by the Medical Consultant's Committee (based on claim detail, patterns of practice, physician records and patient evidence) and found to have been rendered as a result of direct solicitation by a physician, and found to be medically inappropriate are not insured by MCP. However, it is recognized that a small percentage of patients who require periodic medical assessment may be incapacitated or otherwise unable to visit their doctor's office. In these instances, where medical necessity can be clearly demonstrated, it is not deemed to represent solicitation.

A physician, who notifies patients who are part of a target population designated by the **HCS** for immunization that it is time to receive the injection, is not deemed to be "soliciting visits".

A recall program of women for **speculum exams** will not be viewed by MCP as constituting solicitation.

GENERAL PREAMBLE

- (f) services provided as a result of medical research and experimentation.

Medical and professional services which are research-related or experimental are not insured and are not the financial responsibility of MCP. Only those services related to routine, accepted care of a patient's problem and that are not in support of the research related or experimental services are considered to be insured services.

3.3 Common Elements of Insured Services

Elements that are common to all insured services, and therefore not billable as an additional item to either MCP or the patient, are:

- (a) being available to provide follow-up insured services to the patient and making arrangements for coverage when not available,
- (b) making any arrangements for appointment(s) for the insured service,
- (c) making arrangements for any related assessments, procedures or therapy and/or interpreting results,
- (d) obtaining and reviewing information (including history taking) from any appropriate source(s) so as to arrive at any decision(s) made in order to perform the elements of the service, unless stated otherwise,
- (e) obtaining consents or delivering written consents,
- (f) keeping and maintaining appropriate physician's records,
- (g) preparing or submitting documents or records or providing information for use in programs administered by the **HCS**,
- (h) conferring with and/or providing advice, direction, or information to physicians and other health professionals associated with the health and development of the patient. However, **family physicians** who are eligible and registered with the Fee Code Initiative of the Family Practice Renewal Program may bill fee code 520 (Shared Care),
- (i) providing premises, equipment, supplies and personnel for the common elements of the service, and
- (j) direct physical encounter with the patient including any appropriate physical examination and ongoing monitoring of the patient's condition where indicated, unless specifically listed as a "monitoring only" fee.

GENERAL PREAMBLE

4. CLAIM SUBMISSION AND DOCUMENTATION REQUIREMENTS

- 4.1.1 All service items billed to MCP are the sole responsibility of the physician rendering the service with respect to appropriate documentation and billing.
- 4.1.2 If a specific fee code for the service rendered is listed in the Payment Schedule, that fee code must be used in claiming for the service, without substitution.
- 4.1.3 Claims for services rendered in hospitals and long term care facilities must include the hospital/facility number of the institution where the service was rendered.
- 4.1.4 For all services in the In-Hospital Diagnostic, Radiology and Nuclear Medicine Sections, the date of service is the date the service is reported rather than the date the patient is subject to the procedure. For all other services, date of service is the date of patient contact.
- 4.1.5 Documentation of services which are to be billed to MCP must be completed before claims for these services are submitted to MCP.
- 4.1.6 All claims submitted must be verifiable from the physician's records with regard to the examination and/or procedure claimed. Where specific elements of record requirement are listed in this Preamble, but do not appear in the patient record of that service, that element of the service is deemed not to have been rendered and the fee component represented by that element is not payable.
- 4.1.7 A physician shall, upon request by MCP, make available to MCP copies of patient records as may be required to clarify or verify services for which fees have been claimed.
- 4.1.8 For MCP Audit purposes, it is required that physicians maintain records supporting services billed to MCP for a period of six years. MCP Audit is routinely two years.

4.2 Minimum Required Documentation for Claims**4.2.1 Consultations**

See Section 6.2

4.2.2 Visits

To be claimed as an insured service, the minimum record of a visit must include:

- (a) patient identification which includes the patient's name and MCP number,
- (b) date of service for which payment is being claimed,
- (c) reason for the visit e.g. presenting complaint or other reason for that visit, and
- (d) findings through history, physical examination, working diagnoses, and/or plan of investigation or treatment.

GENERAL PREAMBLE

4.2.3 Timed Based Services

- (a) Where a premium fee is applicable based on the time the service is rendered, the starting time indicator for that service must appear in the patient's record. (For home visits, an approximate time will be sufficient).
- (b) Where the fee payable is based on time units, the start and finish times for time unit fees for which payment is being claimed, must be part of the patient record of that service.

4.2.4 Procedures

When a procedural fee is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the fee(s) claimed. For all services listed in the In-Hospital Diagnostic, Radiology, and Nuclear Medicine Sections, the date of service is the date the service is reported rather than the date the patient is subject to the procedure. For all other services, date of service is the date of patient contact.

For additional documentation requirements, refer to the specific codes being claimed.

4.3 Independent Consideration (IC)

4.3.1 Specific services in this Schedule are designated as billable on an IC basis only. Physicians are required to identify claims for these services as IC and to provide additional applicable information, according to instructions in this Schedule or the Physician's Information Manual (PIM).

4.3.2 Services not specifically defined in this Schedule, or for which a set fee is not listed, must be billed IC. For these services an IC claim must include:

- (a) the time involved in direct continual attendance with the patient or in performing the procedure claimed, whichever applies,
- (b) a list of all examinations and procedures performed which are represented by the claim,
- (c) the actual size of lesions removed or laceration repaired, or the area of any defect which was repaired, if applicable,
- (d) comparison in scope and difficulty of the procedure with other procedures defined in the Payment Schedule, and
- (e) a copy of the operative report along with the actual operating time for complex surgical procedures.

4.3.3 New technology services which are under review by **HCS** may be billed IC with approval by **HCS**.

4.4 Use of Provider Number

4.4.1 Claims must be submitted using the Provider Number of the physician who actually rendered or directly supervised the service.

4.4.2 Physicians are required to request prior approval from MCP for all arrangements where payment is to be directed to a designated payee. The claim must indicate a designated payee in the Payee Number Section.

GENERAL PREAMBLE

4.5 Time Limitations on Claim Submission

- 4.5.1 All claims must be submitted within 90 days of the date of service. In exceptional circumstances this time period may be extended as per the MCP Late Claims Policy which is available on the MCP website. A letter giving a full explanation for lateness must be submitted to the Manager of Claims Processing for special consideration.
- 4.5.2 All queries from MCP must be answered within the times specified on the queries. If no time is specified, a reply must be received within 90 days of the date of query.
- 4.5.3 All requests for changes to claims and queries on them must be submitted within 90 days after the date of payment for the claims concerned.

GENERAL PREAMBLE

5. DEFINITIONS OF TERMS/CONDITIONS**5.1 Site of Insured Visit Services**

5.1.1 **Office Visit** – is a service rendered to a patient in a physician’s office or home.

5.1.2 **Home Visit** – is a service rendered following travel to a patient’s home or normal place of residence.

- (a) Patients seen in a nursing home other than one listed in Appendix C, rest home, boarding home or similar setting should be claimed as home visits, with the appropriate home visit fee code being claimed for the first patient seen. Additional patients seen during the same visit should be claimed as extra patients seen.
- (b) Visits by Family Physicians to residents of HCS designated long term care facilities (see Appendix C) must be claimed using dedicated nursing home visit codes for **Family Medicine**. The home’s facility number must be entered on claims for these services.
- (c) Patients seen in the same apartment complex: The first person seen should be claimed using the appropriate home visit codes. Other patients seen within the same apartment should be claimed as extra patients seen. A visit to another apartment in the same complex should be claimed as a separate home visit with the same rules applying to additional patients seen.
- (d) Visits to two apartments in a private dwelling are regarded as visits to two separate homes and should be claimed accordingly.

5.1.3 **Hospital In-Patient** – is a visit by the physician to a registered hospital in-patient. For claiming purposes, MCP recognizes facilities designated by the **HCS** as hospitals. The following rules apply regardless of diagnosis and referring physician:

- (a) When a patient is admitted to a hospital and the attending physician has not claimed for a major examination of the patient within the previous 30 days, the initial in-patient visit may be claimed as a major examination (i.e. Consultation, General or Specific Assessment) according to the service rendered.
- (b) If the attending physician has claimed for a major examination on the patient within the previous 30 days, the initial in-patient visit may only be claimed as a reassessment or lesser visit code.
- (c) In the case of in-patients, the attending physician may claim only one major examination (Consultation, General or Specific Assessment, General or Specific Reassessment) per admission except when the patient is transferred to a physician in a different specialty. In such cases, if the physician who attended the patient initially in the admission is requested by the (new) attending physician to see the same patient, they may claim the appropriate examination. A short explanation justifying this service is necessary.
- (d) If a physician sees a non-critical patient in the OPD, at home or in the office and admits the patient to hospital on his/her own service, on the same day, only one assessment/consultation or reassessment for that day’s service to the patient is payable.

GENERAL PREAMBLE

5.1.4 **Hospital Out-Patient or Emergency Department** - is a visit by the physician to the Out-Patient or Emergency Department of a hospital for the purpose of rendering a service to a beneficiary who is not a registered in-patient of that institution.

5.1.5 **Visits to Other Sites** - Occasionally, based on medical necessity, physicians may be requested to provide insured services to beneficiaries at sites other than the designated sites listed above. There are no visit codes specific to these sites, but the visit may be charged to MCP by claiming a fee commensurate with the service rendered.

5.2 **Delegated Procedure**

When a procedure(s) is carried out by a physician's employee(s) under the direct supervision of the physician in their office, claim(s) may be made for those procedure(s) which are generally and historically accepted as those which may be carried out by the nurse or other medical assistant in the employ of the physician. "Procedures" in this context do not include such services as assessments, consultations, psychotherapy, etc. Direct supervision requires that, during the procedure, the physician be physically present in the office or clinic at which the service is rendered. While this does not preclude the physician from being otherwise occupied, they must be in personal attendance to ensure that procedures are being performed competently and they must at all times be available immediately to approve, modify or otherwise intervene in a procedure as required in the best interest of the patient.

5.3 **Age (unless otherwise specified):**

- (a) Newborn (neonate) - up to and including 28 days of age,
- (b) Infant - 29 days up to but less than 2 years,
- (c) Child - 2 years up to and including 15 years,
- (d) Adolescent - 16 years up to and including 17 years, and
- (e) Adult - 18 years and over.

5.4 **Most Responsible Physician**

5.4.1 The most responsible physician is the attending physician who is primarily responsible for the day to day care of the patient in hospital. In cases where the consultant assumes the role of the most responsible physician, the consultant may claim Subsequent Hospital Visits (SHVs) and the **family physician** may claim Supportive Care, if applicable.

5.4.2 Where the **family physician** remains the most responsible physician and request only a consultation, the **family physician** may claim SHVs and the consultant may claim a consultation only. Subsequent assessments by the consultant during the same admission may only be claimed as SHVs and must be requested by the attending physician.

5.5 **Referral and Transferral**

5.5.1 A **referral** takes place when one physician requests for their patient the services of another physician. The services of the latter may consist of:

GENERAL PREAMBLE

- (a) an opinion (i.e. a consultation),
 - (b) diagnostic tests or procedures (e.g. skin test, biopsy, etc.), and
 - (c) treatment (surgical or medical)
- 5.5.2 A referral also takes place when a primary care physician is not available and a Nurse Practitioner **or Registered Nurse (RN) prescriber** request for his or her patient the services of a specialist physician and it is appropriate to the patient needs and practice setting to do so as described in the **applicable** Regulations.
- 5.5.3 A **transferral**, as distinguished from a referral, takes place where the responsibility for the care of the patient is completely transferred permanently or temporarily, from one physician to another (e.g. where the first physician is leaving temporarily on holidays and is unable to continue to care for the patient).
- Transferral to a physician in the same specialty or discipline should be considered as continuing care and the physician to whom the patient is transferred is not entitled to claim for a consultation.
- 5.5.4 For hospital in-patients, transferral to a physician in the same specialty or discipline should be considered as continuing care and SHV rates are payable as for one period of hospitalization. The visit fee on the date of transfer is payable only to the second physician. In such cases, the physician to whom the patient is transferred is not entitled to claim for a major exam. When a patient is transferred to a physician in another specialty, the patient is deemed to have been referred and the rates payable are as for a new admission. Where the family physician transfers the day-to-day responsibility for the care of the patient to the consultant for a period of time, the consultant should claim on a per diem basis and the family physician should not claim for the period.
- 5.5.5 Physicians who are substituting for other physicians should consider that patients of the other physician have been temporarily transferred (not referred) to their care. The physician to whom the patient is transferred should be regarded as substituting for the other physician.
- 5.5.6 When a specialist assesses a non-referred patient, the service should be claimed using the specialist fee code billed at the corresponding **Family Medicine** rate. If there is no equivalent **Family Medicine** code, then the service should be billed at the rate for **Family Medicine** fee code 121. In either case, the claim must be identified as non-referred.
- 5.6 **Team Care in Teaching Units**
- 5.6.1 When a patient is seen in a Clinical Teaching Unit by a member of a medical team consisting of a staff physician (teacher - physician) and resident, intern or clinical clerk, the staff physician may bill for the services rendered subject to the following conditions:
- (a) The responsible staff physician must assume full responsibility for the appropriateness and the quality of the services rendered. Claims rendered should be in the name of the responsible staff physician. The billing physician must document, by signing the patient record, that they actually supervised the service that was provided or saw the patient for whom the visit was billed.
 - (b) In order to claim for physician procedures being carried out by an intern or resident, the responsible staff physician must be in the clinical teaching unit and immediately available to intervene.
-

GENERAL PREAMBLE

- (c) In a **family medicine** setting, the staff physician should only claim for visits (except SHVs) on the days when actual supervision of that patient's care takes place through the presence of that staff physician in the clinical teaching unit on that day. This, of course, involves a physical visit to the patient and/or a chart review with detailed discussion with the other member(s) of the health team.
 - (d) In all other specialties the responsible staff physician must be present in the clinical teaching unit at the time the services are rendered and must be identified to the patient.
 - (e) In psychotherapy, where the presence of the staff physician would distort the psychotherapy milieu, it is appropriate for the staff physician to claim for psychotherapy when a record of the interview is carefully reviewed with the intern or resident and the procedure thus supervised. However, the time charged by the staff physician may not exceed the total time spent by them in both such interview and direct supervision and should not exceed the total time spent by a physician with the patient.
 - (f) In those situations where on a regular basis a staff member might supervise multiple procedures or services concurrently through the use of other members of the team, the total claims made by the staff physician shall not exceed the amount that the staff physician might make in the absence of the other members of the team.
- 5.6.2 The fees for services rendered in Clinical Teaching Units shall be those established for the profession as a whole.

GENERAL PREAMBLE

6. DEFINITIONS/REQUIREMENTS OF SPECIFIC VISIT CODES-CONSULTATIONS**6.1 General Definition**

“**Consultation**” refers to the situation where licensed physicians or Nurse Practitioners **or Registered Nurse (RN) prescribers** request the opinion of a physician competent to give advice in their field because of the complexity, obscurity or seriousness of the case. Except where otherwise specified, the consultant is required to obtain a complete history and perform a physical examination commensurate with the presenting complaint, review pertinent x-ray films, laboratory or other data, and submit their opinion and recommendations to the referring physician, **NP or RN prescriber**.

6.2 Documentation

The acceptable method of documenting consultations will vary according to the site where the service is rendered:

- (a) Office or scheduled OPD clinic consultations must be documented with a written request from the referring physician, a record of the history and physical examination, and a letter back to the referring physician.
- (b) For in-patient consultations, the written request, history and physical examination, and reply to the referring physician must be documented on the patient’s hospital chart or the official hospital “Consultation Report” form.
- (c) For emergency department consultations made at the request of the emergency physician, the written request, history and physical examination, and reply to the referring physician must be documented on the patient’s emergency department record or the official hospital “Consultation Report” form.
- (d) Emergency department consultations made at the request of a physician who saw the patient in the community or at another facility must be documented with a written request from the referring physician, a record of the history and physical examination, and a written reply to the referring physician.

6.3 General Rules

6.3.1 Subject to Preamble limitations, a consultation fee may be claimed in addition to the fee for surgical, diagnostic or therapeutic procedures performed.

6.3.2 Not more than one major examination (Consultation, General Assessment, or Specific Assessment) per patient per physician may be claimed within a 90-day period except in case of a true emergency on a subsequent occasion. Such claims must be submitted IC clarifying the nature of the emergency.

This rule applies regardless of diagnosis and referral source.

6.3.3 A consultant may claim one major examination for long stay (chronic care) patients, (if requested to see the patient again) every 90 days. All other visits must be claimed as SHVs.

This rule applies regardless of diagnosis and referral source.

GENERAL PREAMBLE

- 6.3.4 If a physician sees a non-critical patient in the OPD, at home or in the office, and admits the patient to hospital on their service, on the same day, only one consult/visit fee for that day's service to the patient is payable.
- 6.3.5 For in-patient consultative services, when the attending physician maintains day-to-day responsibility for care, and requests only a consultation, the attending physician should claim on a per diem basis and the consultant should charge only a consultation fee. Follow-up visits by the consultant must be requested by the attending physician and claimed only as concurrent care using fee code 360.
- 6.3.6 A consultation is not to be claimed when:
- (a) the patient presents to a consultant's office without the prior knowledge of the primary physician. The sending of a report to the primary physician under these circumstances does not justify a consultation.
 - (b) the primary physician is not asked for professional advice but is simply asked by the patient for the name of a specialist in a particular field and the patient seeks out the specialist themselves,
 - (c) consults are a result of hospital policy, or
 - (d) a patient is assessed by an Anaesthesiologist in an organized pre-anaesthetic clinic, regardless of referral,
 - (e) a physician is asked to provide surgical assistant's services.
- 6.3.7 A subsequent consultation requires all of the elements of a full consultation and implies interval care by the primary physician. The situation in which the consultant requests the patient to return for a later examination is not to be claimed as another consultation, regardless of the interval between the earlier examination and the follow up examination. Each consultation claimed must be the result of a new referral. Referral letters solicited by consultants for follow up examinations do not meet the definition or requirements for billing consultations.
- 6.4 **Major Consultations:** These visit codes are to be claimed when a normal consultation does not recognize the time, effort and complexity involved in the case. The categories and description of Major Consultations are as follows:
- 6.4.1 **Comprehensive Geriatric Assessment:** This service is payable when a Royal College certified specialist in Geriatric Medicine or a family physician with a Certificate of Added Competence in Care of the Elderly completes a Comprehensive Geriatric Assessment (CGA). A CGA is indicated for patients aged sixty-five years and older who show signs of frailty or for those younger than sixty-five years with cognitive decline.

Exact start and stop times recording a direct patient interaction of at least ninety minutes are required for payment of the CGA. A CGA is payable only once per patient per lifetime. The geriatric surcharge cannot be billed with the CGA.

The medical record of a CGA must include a diagnostic history and physical examination including assessment of comorbidities, medications, social factors, geriatric syndromes, mobility, cognition and function with recommendations for management.

GENERAL PREAMBLE

6.4.2 **Major Medical Consultation:** This service may only be claimed by specialists in Anaesthesiology, Internal Medicine and Paediatrics and consists of a general assessment of the patient and findings of disorders in three major systems which result in three separate diagnoses requiring investigation and treatment by the consultant.

The minimum time period for major medical consultations (to be claimed as such) is 50 minutes. The start and finish times or duration of the service must be part of the patient record for that service.

A Major Medical Consultation may not be claimed:

- (a) when associated with a diagnostic or therapeutic procedure performed by the same physician (e.g. GI endoscopy, cardiac angiography, etc.), except for office ECGs,
- (b) when performed as a pre-operative consult rendered within 48 hours of the surgical procedure, and
- (c) for pre-arranged patient admission to chronic care facilities.

6.4.3 **Trauma Consultation:** This service may be claimed by specialists in General Surgery, Neurosurgery and Orthopaedic Surgery and consists of evaluation and management of a patient with multiple major systems trauma which requires consultation to other surgical specialties and coordination of the patient's care by the attending surgical specialist.

6.4.4 **Major Surgical Consultation:** This code is to be claimed for services rendered by a surgeon to a patient who is severely ill and whose condition requires a minimum of 50 continuous minutes of attendance for assessment and stabilization.

The start and finish times or duration of the service must be part of the patient record for that service.

6.4.5 **Back Consultation:** This is payable only to Orthopaedic Surgeons for consultative services provided to a patient with a suspected spinal disorder.

6.4.6 **Special Ophthalmology Consultation:** This is payable only to Ophthalmology Specialists. It is applicable to claims for consultative services requested by a Neurologist, Paediatric Neurologist, Neurosurgeon or another Ophthalmologist, where decisions regarding medical or surgical treatment are complicated or require extra consideration, judgment and implementation of specialized knowledge and experience. It also applies to consultative services (and the use of low vision aids) provided to "low vision" patients registered with the CNIB and requiring low vision aids.

The minimum time period for special ophthalmology consultations (to be claimed as such) is 40 minutes. The start and finish times or duration of the service must be part of the patient record for that service.

GENERAL PREAMBLE

- 6.4.7 **Major Neurological Consultation:** This service rendered by a Neurologist shall consist of a detailed assessment of a patient with a complex neurological problem.

The minimum time period for major neurological consultation (to be claimed as such) is 50 minutes. The start and finish times or duration of the service must be part of the patient record for that service.

- 6.5 **Prenatal Consultation:** This service is payable to a Paediatrician or Neonatologist for a requested consultation on a high-risk fetus between 16 and 32 weeks gestation upon referral from an Obstetrician or Perinatologist. Only one prenatal consult is payable per pregnancy per physician. This code is to be billed using the mother's MCP number. Detention is not payable with this service.

- 6.6 **Intraoperative Consultation:** This service may be claimed when a consultant is called to the operating room by the operating surgeon to give advice when a case is complicated and/or additional judgement, based on specialized knowledge and experience, is required.

The consultant should review the pertinent history, intraoperative findings, x-ray and laboratory data as necessary, and submit their opinion and recommendations in writing to the referring surgeon.

- 6.7 Consultations required of Psychiatrists under the Mental Health Act, or by court order, are payable by MCP. The patient record must show that the attending Psychiatrist performed an examination commensurate with needs of the patient.

- 6.8 **Nuclear Medicine Therapeutic Consultation:** Is only payable when no isotope treatment is carried out. It is intended to recognize evaluation of the patient for whom treatment is found and to be not indicated. To claim this fee the Nuclear Medicine Specialist is required to obtain from the patient a full history of the presenting problem, to perform a full physical examination (General Assessment) of the patient and review laboratory reports with respect to the requested treatment with non-sealed radioisotopes. When the decision is made to not proceed with the requested treatment or with any alternative treatment, a consultation report shall be sent to the physician who requested the isotope treatment, stating all the above findings and giving the basis for the decision to not proceed. This service may be claimed as often as it is medically necessary.

- 6.9.1 **Diagnostic Radiology Consultation:** A diagnostic radiology consultation applies when insured imaging studies made elsewhere are referred to a Radiologist for his/her written opinion. It is not payable for the reading of insured imaging studies sent for reporting. As well, a consultation does not apply when the insured imaging studies, referred to above, are used for comparison purposes with images made in the consultant's facilities. Claims for consultation must be submitted IC and accompanied by a copy of the referring letter and the Radiologist's report. This service may be claimed as often as it is medically necessary.

- 6.9.2 **Interventional Radiology Consultation:** An Interventional Radiology (IR) Consultation applies when an Interventional Radiologist is requested by a physician, nurse practitioner or RN prescriber to assess a patient referred for an interventional radiological procedure which requires extensive discussion with the patient. Examples of such procedures include, but are not limited to, the following: endovascular obliteration of cerebral aneurysms and vascular malformations including pelvic congestion syndrome, embolization of uterine fibroids, percutaneous image guided radiofrequency ablation of solid tumours, trans-arterial chemo embolization. The IR consultation is not payable for the following procedures: simple biopsies or aspirations; the routine task of obtaining consent; or for any procedures where direct
-

GENERAL PREAMBLE

interaction with the patient is not warranted. The Interventional Radiologist must give their opinion in writing to the referring physician, nurse practitioner or RN prescriber. This opinion must include documentation of the pertinent patient history and physical examination, and a discussion of the risks and limitations of the procedure. The consultation is payable whether or not the Interventional Radiologist actually performs the procedure.

Billing of an IR Consultation is restricted to those physicians certified by the Royal College of Physicians and Surgeons of Canada in Interventional Radiology. Other Interventional Radiologists may be considered upon request to the Assistant Medical Director.

- 6.10 **Dermatology Consultation in a HCS Designated Long Term Care Facility:** This is payable only to Dermatology Specialists. It is applicable to claims for elective consultative services requested by a staff **Family Physician, Nurse Practitioner or RN prescriber** on behalf of a patient with a complex dermatological problem. The service is rendered to a resident of a **HCS Designated Long Term Care Facility** in that facility. **HCS Designated Long Term Care Facilities** are listed in Appendix C of this Preamble. The facility number must be entered on the claim. The service should be documented on the resident's chart.

Special visit premiums do not apply to elective consultations. Emergency consultations and special visits must be billed using appropriate consultation, visit and premium fee codes.

- 6.11 **High Risk Perinatal Consultation by Maternal-Fetal Medicine Specialist:** A high risk perinatal consultation is a consultation by a maternal-fetal medicine specialist requiring a minimum of 40 minutes of contact with the patient for the management of a documented significant maternal and/or fetal risk factor(s) where the mother and/or fetus are at significant risk for serious complications during the pregnancy.

The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

A regular consult would still apply in cases where:

1. the condition does not pose a significant risk for pregnancy (for example, the patient is referred for hypothyroidism, but upon seeing the patient she is no longer hypothyroid or is well controlled on meds.)

OR

2. the maternal-fetal medicine specialist spends less than 40 minutes in contact with the patient. This may occur where the significant risk does not require 40 minutes for the consult (for example, a woman referred for advanced maternal age and who has no other complications would not usually require a 40 minute consult.)

- 6.12 **According to MCP policy, eligibility for billing consultations is restricted to those Family Physicians belonging to one or more of the following categories:**

- (a) those having additional expertise, obtained via formal training;
- (b) those asked, in the absence of an appropriate specialist, to see a patient whose illness is so severe and/or complex that assessment by a second physician is deemed medically necessary;

GENERAL PREAMBLE

- (c) those practicing full time in a specialty where the consultation is in reference to a medical problem appropriate to that specialty;
 - (d) those who receive a referral from a specialist requesting **family medicine** expertise;
 - (e) Palliative Care Unit physicians asked to assess patients' suitability for admission to the PCU;
 - (f) Miller Centre Physicians asked to assess patients' suitability for admission to the Rehabilitation Unit.
 - (g) **those prescribing methadone or suboxone for opioid dependence.**
- 6.13 **Psychiatry Emergency Department Consultation:** This service may only be claimed by Psychiatrists and consists of unscheduled evaluation and management of a patient with an acute mental health crisis. This fee code can only be claimed when a patient is assessed in a hospital emergency department on an urgent basis.

GENERAL PREAMBLE

7. DEFINITIONS/REQUIREMENTS OF VISIT CODES OTHER THAN CONSULTATIONS

This section contains definitions and/or descriptions of services which are listed in the Consultations and Visits Section of the Payment Schedule. In order to facilitate location, the services are arranged alphabetically according to the letter which is printed in boldface type and underlined in the Consultations and Visits Section.

Unless otherwise stated, the term visit used in this Schedule means each separate and distinct time a physician provides services to a patient in a given day. To be recorded as separate visits, 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 visit(s) or the physician is requested to attend the patient by hospital or nursing home staff based on medical necessity, additional visits and/or premiums may be claimed.

7.1 Add-on Fee for Scheduled After Hours Family Medicine Clinics

- (a) Fee code 139 can be billed by **Family Physicians** who see patients in regular scheduled clinics between the hours of 6:00 p.m. and midnight on weekdays, on weekends, or on MCP Statutory Holidays. It can be billed in addition to **Family Medicine** fee codes 101, 111, 112, 114, 118, 121, 122, 123, 124, 126, 127, 131, 132 and 136. It is not payable with any other codes;
- (b) Fee Code 139 is not payable when special visit codes either 50, 52 or 53 are claimed;
- (c) To document this code for services rendered on weekdays between 6:00 p.m. and midnight, the start time for the patient encounter must be entered on the record of service for the associated visit code. For weekends and MCP Statutory Holidays, the date of service is sufficient.

7.2 Attendance at High Risk Delivery

This service may be claimed by a Paediatrician (or by a **FP** in the absence of a Paediatrician) who is requested by the attending physician to care for the newborn at a high risk operative delivery. In cases of multiple births, 100% is payable for each additional infant being managed by the same physician. Where Preamble requirements are met, claims for consultation and/or assisting at an operative delivery may be payable in addition.

7.3 Case Consultation

This service may be claimed by Psychiatrists who consult with a child welfare or correctional worker, teacher, community health nurse, or other allied professional, in person, on behalf of a child or adolescent.

7.4 Chronic and Convalescent Care

The physician shall be remunerated for this care on a per visit basis with a maximum of one visit every five days. If the patient is seen for the first time on admission, a general or specific assessment may apply in addition to the above fees. In acute illnesses requiring special visits, premiums also apply in addition to fees allowable under the above formula.

GENERAL PREAMBLE

7.5 Complex Assessment

A Complex Assessment is payable to physicians when they are providing dedicated On-Site Emergency Department Coverage at designated hospital facilities listed in Appendix A. The following services qualify for claiming a Complex Assessment:

- (a) Evaluation of a new or existing medical condition that necessitates a detailed medical history, review of previous medical records and necessary physical examination of three or more organ systems. It may include a review of diagnostic tests and the initiation of appropriate therapy/treatment. For the purposes of claiming this code the organ systems are defined as: cardiovascular, respiratory, digestive, genitourinary, musculoskeletal, hemolymphatic, integumentary, nervous, ears-nose-throat, ophthalmic and mental.

OR

- (b) Prolonged observation and/or continuous therapy and multiple reassessments (not including discharge assessment) of patients whose illness requires it. Please note that payment for the discharge assessment is included in the complex assessment fee and is not billable in addition.

OR

- (c) Management of patients presenting with life or limb threatening illness or injury that requires immediate evaluation and/or intervention and/or emergent treatment by the physician.

7.6 Chronic Disease Management

Chronic Disease Management can be claimed when a **family physician** sees a patient under the age of 75 years, in the office setting, for a minimum of 15 minutes where the principle reason for the visit is one or more documented chronic conditions. Other conditions may be dealt with during the same encounter but no other visit fee can be claimed.

The patient record for Chronic Disease Management must include the actual start and end times for the encounter. The patient record must also meet the minimum documentation requirements for visits as described previously in this General Preamble.

The chronic conditions that qualify for billing Chronic Disease Management and the applicable diagnostic codes are:

Chronic Diseases	Applicable Diagnosis Codes
Chronic Obstructive Lung Disease	491, 492, 493, 494, 495, 496
Cancer	140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 170, 171, 172, 173, 174, 175, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208
Inflammatory Bowel Disease	555, 556
Chronic Kidney Disease	581, 582, 583, 585, 587, 589
Chronic Liver Disease	571

GENERAL PREAMBLE

Congestive Heart Failure/Cardiomyopathy	425, 428
Diabetes	250
Mental Health	290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319
Chronic Neurological Disease	138, 330, 331, 332, 333, 334, 335, 336, 337, 340, 341, 342, 343, 344, 345, 741
Ischemic Heart Disease	412, 413, 414
Cerebral Vascular Accident/Trans Ischemic Attack (CVA/TIA)	435, 436, 437, 438
Complex Chronic Infection	010, 011, 012, 013, 014, 015, 016, 017, 018, 030, 031, 046, 070, 084, 087, 090, 091, 092, 093, 094, 095, 096, 097, 137
Chronic Immune Deficiency (includes HIV)	279
Chronic Pain	307
Complex Endocrine Disease	243, 252, 253, 254, 255, 258
Connective Tissue Disorder	710, 711, 713, 714, 720, 725
Peripheral Vascular Disease (PVD)	441, 442, 443

7.7 Concurrent Care

- 7.7.1 This refers to the clinical situation where care by more than one physician is required for a hospital in-patient. Concurrent Care must be verifiable as having been requested by the attending physician. The documentation requirements for Concurrent Care are the minimum documentation requirements for visits as described in this Preamble.
- 7.7.2 Concurrent Care of a registered hospital in-patient is an assessment by a consultant following the consultant's first major assessment. The attending physician continues to be responsible for ongoing care but requests Concurrent Care by the consultant. Concurrent Care in settings other than ICU, NICU or CCU must be billed using fee code 360.
- 7.7.3 Concurrent Care for a patient in an ICU, NICU or CCU must be billed using fee code 51790. Concurrent Care visits made on multiple days should be billed as multiple units of fee code 51790. The date the final visit was made should be used as the date of service for claiming purposes.
- 7.7.4 When a non-IOP surgical procedure is performed on an in-patient by a physician other than the attending physician, the fee payable includes post-operative care for 14 days in hospital. In this case, the patient is considered to have been transferred to the care of the operating physician and the attending physician may not continue to claim for daily care unless the need for such Concurrent Care can be verified. The claim must be billed as fee code 360.

GENERAL PREAMBLE

7.8 Detention

7.8.1 Detention may be charged in addition to a visit when the physician is required to spend extra time in continuous active bedside treatment of a seriously ill patient to the exclusion of all other work, except as noted below.

7.8.2 Detention is not payable for:

- (a) usual preoperative or postoperative care by the operating surgeon,
- (b) the same physician in addition to fees for ICU, CCU and NICU care for the same day unless so specified elsewhere in this Payment Schedule,
- (c) procedural fee codes or in lieu of procedural fees, and
- (d) time spent waiting for x-rays, lab reports, the operating room, patient arrival or for patient transfer to another facility.

7.8.3 Claims for detention must be billed IC and include information as to the nature of the patient's condition requiring physician presence, actual time spent in continuous attendance and a brief description of the service(s) rendered.

7.8.4 Formula for the Claiming of Detention:

- (a) A unit of detention time is a completed 15-minute period. The start and finish times for detention must be part of the patient record of the service.
- (b) All claims for detention must be accompanied by a claim for the preceding visit with the exception of Critical Escorts.
- (c) For specialists' claims, the following times are considered to have been taken up with the visit code claimed:
 - (i) Partial Assessment, Complex Assessment, Subsequent Hospital Visit - first 30 minutes of the service time,
 - (ii) General Reassessment, Specific Reassessment - first 40 minutes, and
 - (iii) Consultation (any type), General Assessment, Specific Assessment - first 60 minutes.
- (c) For **Family Physicians'** claims, detention time units are calculated beginning at the time the patient encounter commences.

7.9 Driver Medical Examination (DME)

7.9.1 **This service is payable when a patient is required, due to age only, to undergo a medical exam to obtain a class 5, 6 or 8 driver's license.**

7.9.2 **A DME is payable only once per patient at age 75 and at age 80, and then every two years after the age of 80. A DME is billable for services provided within 90 days prior to the prescribed interval.**

7.9.3 **No premium codes are billable in addition to a DME.**

GENERAL PREAMBLE

- 7.9.4** If a consultant provides a DME for a patient, as required by Motor Registration because of age, the consultant should submit the claim for Independent Consideration (I.C.) at the Family Physician rate accompanied by a copy of the Medical Examination Report.
- 7.9.5** The documentation requirements for a DME must include a completed Medical Examination Report in addition to the applicable documentation requirements in Section 4.2.2. of the MCP Preamble. In other words, the medical examination report must contain the patients name, MCP number, and date.
- 7.9.6** DMEs required for any other reason besides age, including medical conditions, or additional medical exams requested by Motor Registration remain non-insured services.
- 7.9.7** No other Consultation and Visits fee codes are billable by the same physician for the same patient on the same day as a DME is provided.

7.10 Escort of a Critically Ill Patient

- 7.10.1** Claims for this visit code must reflect the time in actual transit with the patient using the code listed for the service in the “Hospital Out-Patient and Emergency” Section for each specialty. Fee code 482 should be billed regardless of the point of origin or destination of the escort.
- 7.10.2** All Claims must be submitted IC and should include:
- (a) the actual start and finish time for the in-transit period (finish time is defined by the time the patient is transferred to the care of a physician willing to accept responsibility of the patient), and
 - (b) the critical nature of the illness requiring physician presence.
- 7.10.3** A minimum of one unit should be claimed for any escort. Additional units may be claimed for each completed 15-minute period after the first 15 minutes.

7.11 Family Medicine Counselling

Family Medicine Counselling may be billed in addition to an office-based partial assessment when, due to the complexity of the patient problem or situation, a *prolonged* educational dialogue is required. This prolonged educational dialogue occurs between a family physician and a beneficiary with complex health needs or the person(s) most responsible for the care of an infirm or dependent beneficiary with complex health needs. The intent of this service is to develop awareness of the patient’s problems or situation and of modalities for prevention and/or treatment, and information in respect of diagnosis, treatment, health maintenance, and prevention.

GENERAL PREAMBLE

7.11.1 The minimum time period for Family Medicine Counselling (to be claimed as such) is 15 minutes. Claims for one or more units of Family Medicine Counselling should reflect the following requirements of actual documented time spent counselling the beneficiary or person(s) most responsible for the care of the beneficiary.

- 1 unit – 15 to 29 minutes
- 2 units – 30 to 44 minutes
- 3 units – 45 to 59 minutes
- 4 units – 60 to 74 minutes
- 5 units – 75 to 89 minutes, and so on

7.11.2 There is a limit of 125 total units of Family Medicine Counselling per family physician per year.

7.11.3 The patient record must meet the minimum documentation requirements for a partial assessment of the beneficiary as previously described in the preamble.

7.11.4 Start and end times for Family Medicine Counselling must be recorded in the patient record for that service.

7.11.5 The diagnostic code submitted on the claim for the partial assessment must match that of Family Medicine Counselling.

7.11.6 When Family Medicine Counselling is provided to the person(s) most responsible for the care of an infirm or dependent beneficiary, both the partial assessment and Family Medicine Counselling claims must be submitted under the MCP number of the infirm or dependent beneficiary presenting for the partial assessment.

7.12 **General Assessments**

7.12.1 A General Assessment shall consist of a full history, an enquiry into, and an examination of all systems.

Note:

The “clinical need” for a General Assessment rather than a Partial Assessment is also reviewed by the MCP Consultant’s Committee and such relevant notation should also be included in the patient’s record.

7.12.2 For billing purposes, an appropriate record of a General Assessment shall contain information which highlights, at least the positive and significant negative findings for the past history, the functional enquiry and the physical examination. The patient record must show the findings with respect to the cardiovascular, respiratory, and digestive systems and also the findings for at least two of the following systems: genitourinary, musculoskeletal, hemolymphatic, ear-nose-throat, integumentary and nervous systems (central and peripheral).

7.12.3 Provided preamble requirements are met, a General Assessment can be claimed:

- (a) for the first ever visit for the purpose of initiating the use of the birth control pill.
- (b) when a physician admits a patient to hospital and performs the admission history and physical examination of all systems.

GENERAL PREAMBLE

- (c) for evaluation of a patient whose acute condition(s) is/are such that based on signs and symptoms, examination of all systems is medically necessary.

7.12.4 A General Assessment is payable for annual and admission General Assessments rendered to residents of **HCS** designated long-term care facilities listed in Appendix C (fee code 285) and to all other nursing home residents (fee code 210) who require level 2 or 3 care subject to the following conditions:

- (a) only one is payable per nursing home resident per year,
- (d) no other home visit or premium is payable in addition for the same visit to the same resident,
- (c) where applicable, the first patient seen may be claimed as an elective home visit (visit code 246 or 286), rather than as a General Assessment, and
- (e) extra residents seen in addition to the first patient and residents who required admission or annual General Assessments should be claimed using code 252 or code 292.

7.12.5 **A General Assessment cannot be claimed:**

- (a) by physicians when they are providing dedicated on-site Emergency Department coverage at designated hospital facilities listed in Appendix A.
- (b) solely because a patient presents for assessment 90 or more days after a general assessment was previously performed.
- (c) for screening of patients with chronic disease(s) who do not have acute signs or symptoms involving all the body systems.

7.12.6 Not more than one major examination (Consultation, General Assessment, or Specific Assessment) per patient per physician may be claimed within a 90-day period regardless of diagnosis and referral source, except in case of true emergency. Such claims must be submitted IC clarifying the nature of the emergency.

7.13 **General Reassessment**

A General Reassessment shall consist of the same services, terms and conditions and record keeping as a General Assessment except that the service is rendered within 90 days of the previous General Assessment or Consultation.

Not more than one General Reassessment per patient per physician may be billed within a 60-day period, regardless of diagnosis and referral source.

A General Reassessment cannot be claimed by physicians when they are providing dedicated on-site Emergency Department coverage at designated hospital facilities listed in Appendix A.

7.14 **Geriatric Surcharge for Internists**

Specialists and sub-specialists in Internal Medicine may claim a fee in addition to applicable consultation, assessment, reassessment, detention, critical care, and escort codes for patients 65 years of age and older (codes 190, 290, 390, or 490). These codes cannot be billed in addition to

GENERAL PREAMBLE

codes for SHVs, diagnostic and therapeutic procedures, in-hospital diagnostic procedures, and surgical procedures.

7.15 High Risk Prenatal Assessment

A high risk prenatal assessment is an assessment by a maternal-fetal medicine specialist requiring a minimum of 20 minutes in direct contact with the patient for the management of a documented significant maternal and/or fetal risk factor(s) where the mother and/or fetus are at significant risk for serious complications during the pregnancy. The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

7.16 Home Visits by Family Physicians

7.16.1 An **Elective Home Visit** rendered by a **Family Physician** is a visit to a patient's home or normal place of residence which is initiated by the physician in the management of known illness. The fee for elective home visits is the same regardless of the time that the service is rendered, or the type of service provided.

7.16.2 A **Non-Elective Home Visit** rendered by a **Family Physician** is a visit that is requested by the patient or by the patient's attendant and which is made by the physician on the same day. The fee payable for a non-elective home visit is determined by the time or day that the service is rendered. The time of service must be documented on the record for the visit.

7.16.3 For **Extra Patient(s) Seen**, only fee code 252 or 292 as applicable may be claimed.

7.17 In-Patient Surcharges

7.17.1 Fee code 355 may be claimed by **Family Physicians** providing continuing care of hospital in-patients. It is payable during the first seven days of an admission on a per diem basis. It can be billed in addition to the applicable admission assessment code, or SHV code, and code 359.

7.17.2 Fee code 359 may be claimed by **Family Physicians** providing continuing care of hospital in-patients. It is payable once during a period of admission on the day the patient is discharged from hospital. It can be billed in addition to the applicable SHV code and code 355. The billing physician is responsible for preparing the discharge summary, the discharge prescriptions and follow up care as necessary.

7.17.3 Fee code 359 may be claimed by Internal Medicine Specialists and Sub-specialists providing continuing care of hospital in-patients. It is payable once during a period of admission on the day the patient is discharged from hospital. It can be billed in addition to the applicable SHV code. The billing physician is responsible for preparing the discharge summary, the discharge prescriptions and follow up care as necessary.

7.17.4 Fee codes 352 and 353 may be claimed by Psychiatrists providing continuing care of hospital in-patients as the attending physician. Fee code 352 is payable during days 1 to 14 of an admission on a per diem basis. It can be billed in addition to the admission assessment code, or codes 356 and 359. Fee code 353 is payable during days 15 to 28 on a per diem basis and can be billed in addition to codes 356 and 359.

GENERAL PREAMBLE

7.17.5 Fee code 359 may only be claimed by Psychiatrists providing continuing care of hospital in-patients as the attending physician. It is payable once during a period of admission on the day the patient is discharged from hospital. It can be billed in addition to the applicable SHV code. It can be billed in addition to fee code 352 or 353 if applicable. The billing physician is responsible for:

- preparing the discharge summary at the time of discharge and forwarding a copy to the patient's **family physician**. The discharge summary must include:
 - psychiatric diagnosis;
 - medical diagnosis;
 - medication recommendations including:
 - list of medication trials including reasons for discontinuing (i.e. intolerances, allergies, etc.);
 - current medications including recommendation for dosage adjustment and duration of treatment;
 - monitoring that will be required while taking specific medications; and
 - any cautions regarding medications.
 - relevant risk management recommendations (i.e. suicide, psychosis, driving, urine drug screening, etc.); and
 - relevant information from other mental health services to include:
 - interventions utilized;
 - ongoing psycho-social needs; and
 - follow-up required with mental health services.
- providing information and advice to the patient or patient's representative on matters related to the patient's diagnosis/care; and
- arranging follow up care as necessary.

7.18 Interviews

In specific clinical settings, interviews are insured services and may be claimed using the appropriate visit code and the patient's MCP number. Eligibility of claiming for these services is limited to the following specialties:

- Developmental Neurology*
- Paediatrics
- Developmental Paediatrics*
- Physiatry*
- Psychiatry*

*Where the fee payable for interviews is based on time units, the start and finish times of the interview for which payment is being claimed must be part of the patient record of that service.

7.19 Newborn Baby Care

7.19.1 This is the routine in-hospital care of a well-baby for up to 10 days following delivery. This service should include a complete physical examination of the baby and necessary instructions to the mother.

7.19.2 For care of a sick newborn, the appropriate visit codes should be claimed.

GENERAL PREAMBLE

7.20 Partial Assessment

- 7.20.1 This shall consist of the necessary history, an enquiry concerning and the necessary examination of the affected part, region or system. This includes visits for following the progress of treatment and initial visits wherein the patient's condition does not clinically warrant a General Assessment/ Reassessment, or a Specific Assessment/Reassessment.
- 7.20.2 Follow-up visits for monitoring the use of birth control pills qualify as Partial Assessments, with or without fee code 54614, depending on the nature of the examination performed.
- 7.20.3 A visit for a requested **speculum exam** and/or breast examination, without other significant medical complaints or illness, qualifies as a Partial Assessment, with or without fee code 54614, depending upon the nature of the examination performed.

7.21 Partial Assessment of a Patient who is 65 to 74 Years of Age

This is a Partial Assessment of a patient who is 65 to 74 years of age.

7.22 Partial Assessment of a Patient who is 75 Years of Age and Older

This is a Partial Assessment of a patient who is 75 years of age and older.

7.23 Partial Assessment of a Patient Who Received a WHSCC Service during the Same Office Visit

This applies when a physician performs a Partial Assessment of a patient for an MCP insured problem(s) immediately before or after examination/treatment of a problem covered by the WHSCC during the same office visit. This fee code (126) is only billable for non-WHSCC, MCP insured services and should only be billed to MCP.

If the service provided is more extensive than a Partial Assessment (e.g. a General Assessment or Reassessment, Psychotherapy), it should be billed IC giving the reason(s) why a more extensive examination was necessary.

7.24 Psychiatric Management

This applies to Psychiatrists regulating the day-to-day management of patients, when medical necessity requires prescription development, advice and supervision. It may be billed on the days when rehabilitation services are provided to patients seen previously by the Psychiatrist for consultation or assessment. This fee is not meant as an administrative fee for supervising a department of rehabilitation nor is it to be charged on the same day as claims are made for any other services which are provided by the Psychiatrist to the same patient. It applies only to those patients who require and receive frequent attention by the physician during the course of rehabilitation with regard to rehabilitative services of physician and occupational therapy, speech therapy or discharge planning.

7.25 Pre-Anaesthetic Clinic Assessment

- 7.25.1 Fee code 409 is applicable for patients assessed by Anaesthesiologists in organized pre-anaesthetic clinics prior to surgery, including day surgery.

GENERAL PREAMBLE

7.25.2 Consultation fee codes may not be claimed by an Anaesthesiologist in respect of patients assessed in an organized pre-anaesthetic clinic, regardless of referral.

7.25.3 This visit code is not payable in addition to another consultation or assessment performed by the same Anaesthesiologist prior to surgery.

7.26 Pre-Dental General Assessment

This service shall consist of examination and documentation as is required for patients undergoing a general anaesthetic for surgical dental procedures only.

Family Physicians may also bill this code for examination and documentation as is required for:

- i) children and adolescents undergoing diagnostic imaging studies under conscious sedation and:
- ii) patients undergoing a general anaesthetic for ECT.

7.27 Psychiatric Care

7.27.1 This service is any form of assessment and treatment by a Psychiatrist for mental illness, behavioural maladaptation and/or other problems that are assumed to be of an emotional nature, in which there is consideration of, and alteration of the patient's biological and psychosocial functioning.

7.27.2 Charges for hospital visits, home or office fees do not apply on a day when ECT or Psychiatric Care is charged (same diagnosis, same physician).

7.27.3 Psychiatric Care is not payable on the same day as ECT.

7.27.4 Rules for the Claiming of Psychiatric Care

The minimum time period for Psychiatric Care (to be claimed as such) is 15 minutes. Claims for one or more units of Psychiatric Care should be made reflecting the following requirements of actual documented time spent with the patient.

Individual
1 unit – 15 to 44 minutes
2 units – 45 to 74 minutes
3 units – 75 to 104 minutes
4 units – 105 to 134 minutes
5 units – 135 to 164 minutes, and so on

7.28 Psychiatric Day Care

This service may be claimed by Psychiatrists for visits to patients who are seen in a Psychiatry Day Care setting. It is not a per diem rate and may only be billed for a patient with whom an actual exchange took place during that visit.

GENERAL PREAMBLE

7.29 Psychotherapy

- 7.29.1 For purposes of being an MCP-insured service, psychotherapy is defined as the treatment of mental illness, behavioural maladaptions, and/or other problems that are of an emotional nature, in which a physician deliberately establishes a professional relationship with a patient for the purpose of removing, modifying, or retarding existing symptoms, or attenuating or reversing disturbed patterns of behaviour, and/or promoting positive personality growth and development.
- 7.29.2 Psychotherapy may only be claimed when the physician purposefully undertakes to treat the patient's emotional problem and that undertaking must be reflected in both the patient's record and the diagnostic code used on the claim. The patient's record must also include a note of the actual time spent as "psychotherapy" during that visit.
- 7.29.3 Counselling of a patient with a complex non-psychiatric illness is included in the visit fee and should not be claimed as psychotherapy. Marital and family counselling may be claimed as psychotherapy.
- 7.29.4 Charges for hospital visits, home or office fees do not apply on a day when ECT or individual psychotherapy is charged (same diagnosis, same physician).
- 7.29.5 Psychotherapy is not payable on the same day as ECT.
- 7.29.6 The minimum time period for psychotherapy (to be claimed as such) is 15 minutes. Claims for one or more units of psychotherapy should be made reflecting the following requirements of actual documented time spent with the patient.

Individual	Group
1 unit – 15 to 44 minutes	1 unit – 30 to 89 minutes
2 units – 45 to 74 minutes	2 units – 90 to 149 minutes
3 units – 75 to 104 minutes	3 units – 150 to 209 minutes
4 units – 105 to 134 minutes	4 units – 210 to 269 minutes
5 units – 135 to 164 minutes, and so on	5 units – 270 to 329 minutes, and so on

7.30 Routine Post-Operative Care by Family Physicians

Fee codes 118 and 418 must be claimed by **Family Physicians** who provide routine post-operative care to patients during the 42-day post-operative period.

7.31 Sexual Assault Assessment

- 7.31.1 **This comprehensive assessment is performed for the investigation of alleged sexual assault using a sexual assault examination kit.**
- 7.31.2 **A provider cannot bill any other consultation or visit code in association with a sexual assault examination.**

GENERAL PREAMBLE

7.32 Specific Assessment

- 7.32.1 This shall consist of a full history of the presenting complaint, enquiry concerning, and detailed examination of the affected part, region or system as needed to make a diagnosis, exclude disease and/or assess function and advice to the patient.
- 7.32.2 Not more than one major examination (Consultation, General Assessment, or Specific Assessment) per patient per physician may be claimed within a 90-day period regardless of diagnosis and referring source, except in cases of true emergency. Such claims must be submitted IC clarifying the nature of the emergency.

7.33 Specific Reassessment

- 7.33.1 This shall consist of a full relevant history and examination of one or more systems of a patient not requiring a comprehensive evaluation of the patient as a whole.
- 7.33.2 Specific Reassessments apply in the ongoing management and assessment of disease and for following the progress of treatment.
- 7.33.3 The second and subsequent Specific Assessments on a patient within each 90 days should be claimed as Specific Reassessments.
- 7.33.4 Follow-up visits for monitoring the use of birth control pills qualify as Specific Reassessments, with or without fee code 54614, depending on the nature of the examination performed.
- 7.33.5 A visit for a requested **speculum exam** and/or breast examination, without other significant medical complaints or illness, qualifies as a Specific Reassessment, with or without fee code 54614, depending upon the nature of the examination performed.
- 7.33.6 When an Anaesthesiologist is managing post-operative sleep apnea but **not** participating in a Remote Obstructive Sleep Apnea (ROSA) program, the Anaesthesiologist may claim a specific reassessment for patient visits where the billing physician is not also claiming per diem fees and/or non-IOP procedural fees. A maximum of one specific reassessment may be claimed for this purpose per patient per period of admission. For billings related to ROSA, please see section 10 (In-Hospital Diagnostic and Therapeutic Services).

7.34 Specific Neurocognitive Assessment

- 7.34.1 **This is an assessment of neurocognitive function rendered personally by a psychiatrist where all of the following requirements are met:**
- a) **This assessment involves testing memory, attention, language, visuospatial function and executive function. While administration of the Mini-Mental State Examination (“Folstein”) would not be eligible for billing a specific neurocognitive assessment, examples of eligible neurocognitive assessment batteries for billing this service include the short form of the Behavioral Neurology Assessment (BNA) or the Dementia Rating Scale (DRS).**
 - b)

GENERAL PREAMBLE

- c) **This assessment must take a minimum of 20 consecutive or non-consecutive minutes. This time must be dedicated exclusively to assessing neurocognitive function but may include test administration and scoring as long as all components are completed on the same day.**

7.34.2 Start and stop times must be recorded in the record of service.

7.35 Subsequent Hospital Visits (SHVs)

SHVs may be claimed for continuing care of hospital in-patients by attending physicians. These visits are payable on a per diem basis and may only be claimed once for each patient day regardless of the number of actual visits to a patient on any one day. Information on the patient's hospital chart satisfies documentation requirements for SHVs. Premiums for any additional "Special Visits" as defined in this Preamble may be applicable.

7.36 Supportive Care

Supportive Care is the (non-surgical) care rendered in-hospital by the referring **family physician**, who is not actively treating the case (e.g. writing orders), to a patient under the care of another physician at the desire of the patient or family, for purposes of liaison or reassurance. Supportive Care may be claimed by **family physicians** only, using either Visit Code 371 or 372.

7.37 Visit for Procedure Only

When the sole reason for a visit is the performance of a procedure listed in the Diagnostic and Therapeutic Section of the Schedule, visit codes should not be claimed. This service should be claimed by billing the appropriate procedural code and fee code 54000, unless otherwise specified.

7.37.1 Transfer of Care Surcharge

Fee code 160 may only be claimed by Psychiatrists who provide office-based care. It is payable for patients who are discharged from the psychiatrist's practice to their **family physician** with a written treatment plan for the ongoing management of the patient's mental health. The written treatment plan fulfills the documentation requirement for this service. A minimum of six separate follow up visits must occur before code 160 may be billed.

The transfer of care code is intended to assist in the safe transition of appropriate patients, whose medical needs can be managed within primary care, from the psychiatrist to the primary care physician. The billing psychiatrist must meet the established visit requirements for this fee code and must provide a transition of care treatment plan to the **family physician** or designate that will provide guidance on bio-psycho-social recommendations for the patient. This plan must include the following elements:

- psychiatric diagnosis;
- medical diagnosis;
- medication recommendations including:
 - List of medication trials including reasons for discontinuing (i.e. intolerances, allergies, etc.);
 - current medication including recommendations for dosage adjustment and duration of treatment;

GENERAL PREAMBLE

- monitoring that will be required while taking specific medications; and
- any cautions regarding medications.
- relevant risk management recommendations (i.e. suicide, psychosis, driving, urine drug screening, etc.); and
- relevant information from other mental health services to include:
 - interventions utilized;
 - ongoing psycho-social needs; and follow-up required with mental health services.

7.38 Transition-Related Surgical Readiness Assessment

The Transition-Related Surgical (TRS) Readiness Assessment is a comprehensive fee code that may include multiple visits in order to make a recommendation for insured TRS procedures. Recommended content of the surgical readiness assessment is available at [Transition-Related Surgery Coverage - Health and Community Services \(gov.nl.ca\)](https://www.health.gov.nl.ca/health/mcp/pdf/Transition-Related%20Surgery%20Coverage%20-%20Health%20and%20Community%20Services%20(gov.nl.ca).pdf). A TRS Readiness Assessment is payable to the family physician, obstetrician/gynecologist or psychiatrist who possess the minimum credentials for mental health professionals who work with adults presenting with gender dysphoria. These credentials are available at [Transition-Related Surgery Coverage - Health and Community Services \(gov.nl.ca\)](https://www.health.gov.nl.ca/health/mcp/pdf/Transition-Related%20Surgery%20Coverage%20-%20Health%20and%20Community%20Services%20(gov.nl.ca).pdf) (see Surgical Readiness Assessor Certification and Recommendation).

- 7.38.1 The TRS Readiness Assessment is only payable for assessments for TRS procedures that are covered by Newfoundland and Labrador's provincial health insurance plans. A list of insured TRS procedures is available at [https://www.health.gov.nl.ca/health/mcp/pdf/TRS Policy.pdf](https://www.health.gov.nl.ca/health/mcp/pdf/TRS_Policy.pdf). The TRS readiness assessment is payable whether or not the physician recommends the proposed insured surgery.
- 7.38.2 There is no payment available for completion of the TRS Request for Prior Approval.
- 7.38.3 The record of service must meet all the documentation requirements of a visit as described in Section 4.2.2 of the MCP Medical Payment Schedule. If surgery is recommended, the record of service must also include the written surgical readiness assessment as well as the TRS Readiness Assessor Certification and Recommendation form located at [https://www.health.gov.nl.ca/health/mcp/pdf/TRS SRA Cert.pdf](https://www.health.gov.nl.ca/health/mcp/pdf/TRS_SRA_Cert.pdf).
- 7.38.4 There are no other fee codes payable in addition to this fee code for this patient on the same day by the same physician that a TRS readiness assessment is provided.
- 7.38.5 There are no premiums payable in addition to this code.

7.39 Well-Baby Care Visit

This is to be claimed for the periodic visits of a well-baby during the first two years of life involving complete examination with necessary weight and measurement, haemoglobin and urinalysis when indicated, necessary immunization(s) (excluding cost of materials), and instructions to the parent(s) regarding health care. This visit code must be claimed unless the infant is not a "well baby."

GENERAL PREAMBLE

8. CRITICAL CARE**8.1 Neonatal Intensive Care Unit (NICU)**

- 8.1.1 These fees apply to the services of being in constant or periodic attendance during a one day period, to provide all aspects of care to the patients in Neonatal Intensive Care Units designated by the **HCS**. There are three levels of care depending upon the procedures performed.
- 8.1.2 These are team fees which apply to Neonatologists/Pediatricians/Anaesthesiologists providing complete daily care and should be claimed by the physician in charge of the patient. The daily fee includes the initial consultation, subsequent assessments, and the ongoing monitoring of the patient's condition, including the following procedures as required:
- (a) insertions of IVs, arterial and CVP lines,
 - (b) use of pressure infusion sets,
 - (c) endotracheal intubation and tracheobronchial toilet,
 - (d) insertion and maintenance of urinary catheters and nasogastric tubes,
 - (e) securing and interpreting the results of arterial blood gas samples, and
 - (f) the use or artificial ventilation.
- 8.1.3 These fees may be claimed in the post-operative period for patients receiving either Level A or B care. Level C care cannot be claimed for post-operative infants.
- 8.1.4 Physicians not part of the daily care team, whose additional expertise is required, may bill for each item of service performed, including Concurrent Care (fee code 51790).
- 8.1.5 When a patient's care is transferred to a higher or lower level, the second day rate for that level applies. However, in any one period of NICU care, the first day rate for the highest level is payable for the date the patient transferred to that level. Only one first day rate is payable per NICU period.
- 8.1.6 Consultations or other assessments are not payable on transfers out of a NICU to the physician who cared for the patient in the NICU. However, consultations or assessments consistent with Preamble definitions are payable to other physicians, including those in the same specialty as the NICU physician, who render subsequent care to the patient transferred out of the NICU.
- 8.1.7 When a patient is readmitted to the NICU within 48 hours of discharge, second day benefits apply. After 48 hours, first day benefits apply.
- 8.1.8 All claims for NICU must contain the facility number of the hospital in which the service was provided.

GENERAL PREAMBLE

8.2 ICU and CCU Care

8.2.1 These fees apply to the services of being in constant or periodic attendance during a one day period, to provide all aspects of care to patients in Intensive or Coronary Care Units designated by the **HCS**. There are four levels of care depending upon the procedures performed:

- (a) Comprehensive Care – This is the service rendered by a physician who provides complete care (both Critical Care and Ventilatory Support) to Critical Care Area patients. Comprehensive Care fees are not payable for services rendered to stabilized patients in ICUs or patients admitted for ECG monitoring or observation alone.
- (b) Critical Care – This is the service rendered by a physician who provides all aspects of care to a Critical Care Area patient except Ventilatory Support. Critical Care fees are not payable for services rendered to stabilized patients in ICUs or patients admitted for ECG monitoring or observation alone.
- (c) Observatory Care – This is the service rendered to stable ICU or CCU patients without invasive monitoring and without assisted ventilation.
- (d) Ventilatory Support – This is the service provided by a physician other than the one claiming Critical Care. It includes management of the intubated airway, tracheal toilet by suction catheter with or without instillation, and supervision of mechanical ventilation of the critically ill patient.

8.2.2 These are team fees which apply to physicians providing complete daily care and should be claimed by the physician in charge of the patient. The daily fee includes payment for the initial consultation, subsequent assessments, and the ongoing monitoring of the patient's condition, including the following procedures as required:

- (a) insertion of IVs, intraosseous, arterial and CVP lines,
- (b) use of pressure infusion sets,
- (c) endotracheal intubation and tracheobronchial toilet,
- (d) insertion and maintenance of urinary catheters and nasogastric tubes,
- (e) securing and interpreting the results of laboratory tests, oximetry, arterial blood gas samples,
- (f) infusion or injection of pharmaceutical agents, and
- (g) intracranial pressure monitoring, interpretation and assessment.

8.2.3 The following services may be claimed in addition to the daily intensive care fee codes:

- (a) insertion of Swan-Ganz catheter,
- (b) cardiopulmonary resuscitation,
- (c) insertion of transvenous pacemaker,
- (d) all services listed for renal dialysis,

GENERAL PREAMBLE

- (e) electrical cardioversion,
 - (f) endotracheal intubation, where it is necessary to be rendered by a physician other than the physician in charge, and
 - (g) insertion of ICP measuring device.
- 8.2.4 These fees may be claimed in the pre- and post-operative period for patients receiving either Comprehensive, Critical, Ventilatory or Observatory Care.
- 8.2.5 If the patient is transferred to the ICU or CCU directly from the OR or the Recovery Room, second day rates apply. However, when the care required supersedes the normal post-operative care for the surgery performed, and the patient is transferred from the surgeon to the attending ICU/CCU physician, first day rates apply.
- 8.2.6 Physicians not part of the daily care team, whose additional expertise is required, may bill for each item of service performed, including Concurrent Care (fee code 51790).
- 8.2.7 When a patient's care is transferred to a higher or lower level, second day rates for that level applies. However, in any one period of ICU/CCU care, first day rates for the highest level is payable for the date the patient transferred to that level. Only one first day rate is payable per ICU/CCU period.
- 8.2.8 When a patient is readmitted to ICU/CCU with 48 hours of discharge, second day benefits apply. After 48 hours, first day benefits apply.
- 8.2.9 Consultations or other assessments are not payable on transfers out of the ICU or CCU to the physician who cared for the patient in the ICU or CCU. However, consultations or assessments consistent with Preamble definitions are payable to other physicians, including those in the same specialty as the ICU/CCU physician, who rendered subsequent care to the patient transferred out of the ICU or CCU.
- 8.2.10 All claims for ICU and CCU must contain the facility number of the hospital in which the service was provided.
- 8.3 Provincial Perinatal High Risk Unit**
- 8.3.1 The fees listed are only applicable to patients who are admitted to the unit and have been designated as high risk and are payable only to the physician in charge of the patient. The Concurrent Care fee for ICU, fee code 51790, may also be claimed by a second obstetrical specialist sharing in the on-going care of the patient.

GENERAL PREAMBLE

9. DIAGNOSTIC AND THERAPEUTIC SERVICES

- 9.1 This section of the Schedule identifies the amounts payable for miscellaneous professional services. Designation of site for claiming the service is based on where the procedure is performed rather than where it is interpreted.
- 9.2 If a procedure is performed in a hospital and is listed both in this section and the In-Hospital Diagnostic Section, it must be claimed using the fee code listed in the In-Hospital Diagnostic Section.
- 9.3 When a procedure(s) is the sole reason for a visit, no consultation or visit fees should be charged. However, fee code 54000 may be claimed, unless stated otherwise.
- 9.4 Billing rules for immunization of beneficiaries who belong to target populations designated by the **HCS** are as follows:
- 9.4.1 Billing rules when a visit is for immunization only:**
- (a) visit for one adult immunization for target population as described in Appendix D – claim one unit of 54648.
 - (b) visit for more than one adult immunization for target population as described in Appendix D – claim the applicable units of 54648 for every eligible vaccine provided. For example, if Pneu-C-20 is provided at the same time as MMR, bill two units of 54648.
- 9.4.2 Billing rules for a visit for assessment and immunization(s):**
- (a) visit for assessment and one adult immunization for target populations as described in Appendix D – when a patient presents to a physician’s office for a visit unrelated to an insured immunization and also receives an adult immunization listed in Appendix D during the same office visit, the appropriate office visit code may be billed as long as all preamble requirements for that visit are met. In this case, fee code 54649 is also payable for the administration of the vaccine at \$10.00.
 - (b) visit for assessment and more than one adult immunization for target population as described in Appendix D – claim the applicable visit fee code as above in (a) and the applicable units of fee code 54649. For example, if Pneu-C-20 is provided at the same time as MMR to designated target populations and a visit for assessment also occurs, bill two units of 54649 in addition to the applicable visit fee code.
 - (c) if a visit for assessment is billed with an immunization(s), the record of service for that visit must meet the minimum requirements for the applicable visit billed as stated in the MCP Medical Payment Schedule preamble. Appropriate documentation of the immunization(s) is also required.
- 9.4.3 If more than one immunization is provided in the same visit, each immunization must be documented separately.
- 9.4.4 Fee code 54000 is not billable in addition to fee codes 54648 or 54649.

GENERAL PREAMBLE

9.4.5 Premiums cannot be billed with immunization fee codes. However, fee code 139 (“Add on fee for patients seen in scheduled after hours clinics”) remains billable with the applicable fee codes.

9.5 Satellite Haemodialysis

9.5.1 General

- (a) Fee codes 54494 and 54496 are benefits for managing chronic haemodialysis where the patient undergoes dialysis at a **HCS** approved satellite site remote from the site where the billing physician is located.
- (b) For the purpose of claiming these codes “remote” means patient and physician are located in different municipalities and the physician does not attend the patient’s dialysis sessions at the satellite site in person.
- (c) All claims for fee codes 54494 and 54496 must include the facility number of the satellite site where the patient is located. See the MCP Physician Information Manual for a list of numbers.

9.5.2 Supervision and administration – Fee Code 54494

- (a) When fee code 54494 is billed, the claim date must be the last date of each completed week or supervision where a week begins 12:00 a.m. Monday and ends 11:59 p.m. Sunday.
- (b) If the billing physician provides in person dialysis services to the patient at the satellite site, the amount that can be claimed for fee code 54494 that week must be reduced by 50%.

9.5.3 Teledialysis Assessment with Patient, Once Per Week, Per Patient – Fee Code 54496

- (a) “Teledialysis Assessment” is a medical service provided to a chronic haemodialysis patient present at a **HCS** approved satellite haemodialysis site in Newfoundland and Labrador, through a direct interactive video link with a receiving physician at an approved telemedicine site in Newfoundland and Labrador. The patient must be present at the same time as the physician. The physician may initiate the service. This code is payable to a maximum of one physician per patient, per week.
- (b) The record of a teledialysis assessment must include the findings through history, observations from visual inspection (if any), and plan of investigation or treatment. It is understood that the diagnosis is chronic renal failure and that the reason for the visit is review of the dialysis patient’s status.
- (c) When fee code 54496 is billed, the date of service must be the actual date the physician-patient teledialysis encounter took place. For the purpose of billing this code, a week begins 12:00 a.m. Monday and ends 11:59 p.m. Sunday.

9.6 Electrophysiologic Pacing, Mapping and Ablation

- 9.6.1** Fee code 54333 is billable under the following conditions:
The advance mapping system is used in hospital for mapping the following arrhythmias:

GENERAL PREAMBLE

Atrial arrhythmia	Atrial fibrillation Atypical atrial flutter Post-surgical atrial flutter Atrial tachycardia Redo typical atrial flutter Redo reentrant tachycardia (accessory pathways, AV nodal reentry)
Ventricular arrhythmia	Ischemic ventricular tachycardia/premature ventricular ectopics Non-ischemic ventricular tachycardia/premature ventricular ectopics Idiopathic ventricular tachycardia/premature ventricular ectopics (e.g. fascicular, ARVD, bundle branch reentry, aortic cusp, outflow tract, etc.)
Other	Congenital heart disease arrhythmia

9.6.2 Examples of procedures lasting more than 4 hours and not utilizing the advance mapping system are mapping and ablation of multiple accessory pathways and/or thick band accessory pathway(s).

GENERAL PREAMBLE

10. IN-HOSPITAL DIAGNOSTIC SERVICES

- 10.1 This section of the Schedule identifies the amounts payable for professional services related to specific procedures performed in a hospital.

If the same procedures are performed in a non-hospital environment, they must be billed using fee codes and fee in the Diagnostic and Therapeutic Procedures Section.

Diagnostic procedures not listed in the Diagnostic and Therapeutic Procedures Section or the In-Hospital Diagnostic Procedures Section are not MCP insured services.

- 10.2 Only the physician who produces the official hospital report may claim these fees. Interpretations done by attending physicians during care of the patient are considered to be included in the daily care or other fees payable for these patients.

GENERAL PREAMBLE

11. RADIOLOGY

- 11.1 Diagnostic imaging services are insured services under MCP and are payable according to the rates listed in the Radiology Section of this Schedule. The fee codes and fees in this section may be claimed by Radiologists or those physicians designated by individual hospitals to provide imaging services. MCP should be notified in writing by the hospital's administration of the names of physicians so designated and the specific imaging services for which they have been given privileges.
- 11.2 The fees listed include:
- (a) consultation between the Radiologist and referring physician,
 - (b) the procedure and/or interpretation as specified in the fee code item,
 - (c) producing the usual report, and
 - (d) supervision of diagnostic imaging services by the Radiologist.
- 11.3 If the examination requested by the referring physician yields abnormal findings, or if it would yield information which in the opinion of the Radiologist would be insufficient, or if a different examination is necessary to obtain the diagnostic information required, then, governed by the needs of the patient, the Radiologist may add additional views or change the examination and claim accordingly. Such additions or changes must be noted on the examination request form or in the report for that exam and signed by the Radiologist.
- 11.4 Certain procedures require Independent Consideration (IC) submission along with the regular claim. The IC should include all the information necessary for the determination of the appropriate fee. Essential information includes:
- (a) time taken to do the procedure,
 - (b) any medical complication which impacts the procedure,
 - (c) the specific type of scan or examination required,
 - (d) specific circumstances requiring the Radiologist's presence,
 - (e) specific service performed by the Radiologist,
 - (f) reference to any fee code item considered equivalent to the service being performed, and
 - (g) fee requested.
- Note:** See the Physician's Information Manual for requirements specific to codes listed IC.
- 11.5 A stereo pair is to be counted as two views.

GENERAL PREAMBLE

- 11.6 No additional fees are to be charged for:
- (a) rapid sequence IVP,
 - (b) the use of image intensifying equipment,
 - (c) fluoroscopy, when it is regarded as an integral part of the examination, e.g., examination of the GI tract special procedures,
 - (d) routine abdominal and chest studies billed with gastrointestinal examinations, and
 - (e) routine abdominal and/or pelvic views in addition to lumbar spine examination requests.
- 11.7 Conventional films of the spine before myelography may only be obtained and billed if the Radiologist is unable to obtain films done at their or other institutions. IC is required.
- 11.8 An unsuccessful procedure should be claimed as successful. IC is required.
- 11.9 Procedural ultrasound fees must be billed IC and may only be claimed:
- (a) where no technician is available to do the required procedure and the clinical urgency of the case will not permit waiting until a technician is available, or
 - (b) where the technician available is not trained to do the required procedure, or
 - (c) where the procedure is so complicated that it must be performed by, or under the direct guidance of a Radiologist, who must be continually in attendance.
- 11.10 No fee may be claimed for interpretation of views of the joint unless all of the views normally required for that joint have been examined.
- 11.11 IV injection fees are not included in any interpretation fee but are included in procedural fees which normally require intravenous injection.
- 11.12 The fee for a "special additional view" may only be claimed for interpretation of a view which is not considered to be included in the routine examination of that part or area and which has been specifically requested by the referring physician or deemed clinically necessary by the interpreting Radiologist.
- 11.13 When claiming fluoroscopy services, fees are only billable when the Radiologist is present during the procedure, with the Radiologist actively providing or guiding the fluoroscopy.
- 11.14 Complex head CT scans are multi-planar and must include one or more of the following areas: pituitary fossa, posterior fossa, internal auditory meati, orbits and related structures, the temporal bone and its contents, and the temporomandibular joints.
- Fee codes 73800, 73801 and 73802 cannot be billed in addition to fees for complex head studies.
-

GENERAL PREAMBLE

- 11.15 Special visit premiums are payable in addition to the procedural fees. The premiums apply when the Radiologist is asked to return to the hospital after normal working hours as follows:
- (a) Daytime special visit – (Monday to Friday),
 - (b) Special visits during evenings – (6:00 p.m. to midnight, Saturdays, Sundays and Statutory Holidays), or
 - (c) Special visits during the night – (midnight to 8:00 a.m.)
- 11.16 Only one special visit premium per trip to the hospital is payable regardless of the number of x-rays examined. An additional premium is payable for additional trips made within the same shift or period as outlined.

GENERAL PREAMBLE

12. NUCLEAR MEDICINE

- 12.1 Nuclear Medicine services are insured services under MCP and are payable according to the rates listed in the Nuclear Medicine Section of this Schedule. The fee codes and fees in this section may be claimed by Nuclear Medicine Specialists or those physicians designated by individual hospitals to provide such services. MCP should be notified in writing by the hospital's administration of the names of physicians so designated and the specific imaging services for which they have been given privileges.
- 12.2 The fees listed include:
- (a) consultation between the Nuclear Medicine Specialist and referring physician,
 - (b) the procedure and/or interpretation as specified in the fee code item,
 - (c) producing the usual report, and
 - (d) supervision of diagnostic imaging services by the Nuclear Medicine Specialist.
- 12.3 If the examination requested by the referring physician yields abnormal findings, or if it would yield information which in the opinion of the Nuclear Medicine Specialist would be insufficient, or if a different examination is necessary to obtain the diagnostic information required, then, governed by the needs of the patient, the Nuclear Medicine Specialist may add additional views or change the examination and claim accordingly. Such additions or changes must be noted on the examination request form or in the report for that exam and signed by the Nuclear Medicine Specialist.
- 12.4 An unsuccessful procedure should be claimed as successful. IC is required.
- 12.5 IV injection fees are not included in any interpretation fee.
- 12.6 The fee for a "special additional view" may only be claimed for interpretation of a view which is not considered to be included in the routine examination of that part or area and which has been specifically requested by the referring physician or deemed clinically necessary by the interpreting Nuclear Medicine Specialist.
- 12.7 Special visit premiums are payable in addition to the procedural fees. The premiums apply when the Nuclear Medicine Specialist is asked to return to the hospital after normal working hours as follows:
- (a) Daytime special visit – (Monday to Friday), or
 - (b) Special visits during evenings – (6:00 p.m. to midnight, Saturdays, Sundays, and Statutory Holidays), or
 - (c) Special visits during the night – (midnight to 8:00 a.m.)
- 12.8 Only one special visit premium per trip to the hospital is payable regardless of the number of scans examined. An additional premium is payable for additional trips made within the same shift or period as outlined.

GENERAL PREAMBLE

13. OBSTETRICS

- 13.1 The SURGICAL PROCEDURES Section of this Preamble applies to all obstetrical procedures unless otherwise stated.
- 13.2 The delivery fee includes routine in-hospital pre-delivery assessment and daily care as well as the management of labour.
- 13.3 Illnesses or conditions resulting from, or associated with, pregnancy requiring added hospital care should be charged on a per diem basis up to the day prior to delivery. Remarks Code 07 should be indicated on claims for these SHVs.
- 13.4 "Attendance at Labour" is payable when a **Family Physician** refers a patient in labour to another physician for delivery because of complications. If the complication results in a Caesarean or other operative delivery and the **Family Physician** assists, that physician is entitled to the assistant's fee as well as the "Attendance at Labour" fee.
- 13.5 Care of the newborn is not included in the obstetrical fee.
- 13.6 The Anaesthesiologist's services include ordinary and immediate care of the newborn. When active resuscitation is necessary, add three units of anaesthetic time.
- 13.7 Fee code 80010 represents routine post-partum in-hospital care, regardless of the number of days the patient remains in hospital.

GENERAL PREAMBLE

14. SURGICAL PROCEDURES

14.1 Surgical procedural codes and their associated fees are intended to remunerate the physician for all parts of the procedure that are the integral components of the procedure. It is not appropriate to unbundle (de-construct) the procedure into constituent parts and bill MCP for these codes in addition to the procedure codes. Unless otherwise stated, the fee listed for a surgical procedure is a composite fee that includes payment for the following:

- (a) the procedure, including the surgical approach and closure,
- (b) identification and protection of structures within or adjacent to the operative field such as arteries, nerves, ureters, etc.,
- (c) administration of an anaesthetic and/or other medication prior to, during, or immediately after the procedure(s) (unless otherwise specified in this Payment Schedule),
- (d) the use of imaging guidance by the physician(s) performing the procedure,
- (e) all examinations other than consultations rendered within two days prior to the procedure,
- (f) pre-operative care for two days prior to the procedure,
- (g) post-operative SHVs for up to 14 days of care commencing on the day after surgery,

The starting point for the calculation of SHV benefits after the 14 days included in the procedural fee is the date of admission if admitted by the surgeon or the date of transferal, if transferred for another specialty.

When immediate post-operative chemotherapy for malignancy is commenced, SHVs are payable to the physician rendering the service. Claims must be submitted IC.

- (h) routine post-operative office or out-patient visits, for up to 42 days commencing on the day after surgery, are included in the surgical fee and are not eligible to be claimed by another physician in the same specialty as the operating surgeon. However, post-operative visits may be claimed if the patient is seen by a physician in the same specialty as the operating surgeon, and the service is rendered at a site in excess of 16 kilometers from the community in which the surgical procedure was performed. This requires the use of Remarks Code 25 on the claim form.
- 14.2 The following items are not included in the surgical fee and may be claimed in addition, if applicable:
- (a) consultation prior to surgery,
 - (b) subsequent surgical procedures, including Diagnostic and Therapeutic Section fee code, for the same condition,
 - (c) premium on non-elective, non-scheduled surgical procedures,
 - (d) premium applicable to a special in-patient visit requested by the hospital for which a visit fee is not payable,
 - (e) premium for specific, approved major surgical procedure(s) on morbidly obese patients,

GENERAL PREAMBLE

(f) pre and post-operative visits not related to procedure:

Visits made within the 2-day pre-operative period or 42-day post-operative period for a condition unrelated to the one for which the procedure was done, are eligible to be claimed by any physician rendering the service.

Remarks Code 20 must be used by **Family Physicians** claiming these services.

(g) visits related to complications of surgery:

Office, home or out-patient visits made within the 42-day post-operative period because of complications are eligible to be claimed by any physician rendering the service. Remarks Code 24 must be used.

(h) routine post-operative care by Family Physicians:

Family Physicians are eligible to claim office or out-patient visits for routine post-operative care during the 42-day post-operative period. Fee code 118 or 418 must be claimed.

14.3 For claim assessment purposes, a surgeon who performs a non-IOP surgical procedure on a patient is deemed to be the attending physician for the first 14 post-operative in-patient days and for the first 42 total post-operative days.

14.4 When a procedure is specified as “Independent Operative Procedure” (IOP), the procedural fees may be charged in addition to visit fees, consultation, etc.

IOPs when not included in another procedure or visit fee, are payable at the full listed fee whether done alone or with another procedure. Fees for non-IOPs are not affected by IOPs done at the same sitting.

When an IOP is done in conjunction with other non-IOPS, there should be no charge for pre- and post-operative care related to the IOP, but the listed IOP fee should be charged in these circumstances.

When multiple IOPs are performed at the same time by the same physician, the listed procedural fees should be charged in full but the pre- and post-operative visit fees should be charged as if only one procedure had been performed.

14.5 When different operative procedures are done by two different surgeons under the same anaesthetic for different conditions, the fee will be 100% of the listed fee for the major procedure for each surgeon.

14.6 If the nature or complexity of a procedure requires more than one operating surgeon, each providing a separate service in a specialized field, each surgeon may claim the full listed fee for the procedure performed. This however, does not apply to those cases where an additional surgeon is involved simply because they may be more skilled in carrying out the procedure. Neither does it apply to those cases where one or more additional surgeons perform components of a main procedure for which there is listed a combined tariff. In those cases, the additional surgeon may claim assistant's fee only for the procedures.

14.7 When more than one operative procedure is performed by the same surgeon at the same time under the same anaesthetic, the fee shall be the full fee for the major procedure and all other procedures shall be paid at the rate of 85% of the listed fee for each procedure (exception: IOPs). However, in the case where an appendix or ovarian cyst(s) is removed incidentally during an operation, no additional charge should be claimed.

GENERAL PREAMBLE

- 14.8 When a patient is re-admitted to hospital because of a post-operative complication which does not require a surgical procedure, the physician attending this re-admitted patient should claim as for a new admission.
- 14.9 When an emergency surgical procedure is performed in the course of a home visit, the visit fee should be charged in addition to the procedure fee. A note of explanation is required to expedite processing.
- 14.10 Procedures that are non-elective, unscheduled, and which either require the services of an Anaesthesiologist, or which are performed using one of the regional nerve blocks specified in fee code 54150 for local anaesthetic purposes, qualify for premiums as listed in the Premiums Section of the Preamble.
- 14.11 When a physician administers an anaesthetic and/or other medication prior to, during, or immediately after a procedure(s) which the physician performs on the same patient, the procedure(s) only should be claimed. However, when a physician administers a retrobulbar, stellate ganglion, femoral, sciatic, ilioinguinal, iliohypogastric, ulnar, median, radial block for local anaesthetic purposes, or epidural for delivery block in addition to performing the procedure, fee code 54150 should be claimed in addition to the procedure fee.
- 14.12 Where hypothermia is used, a charge in addition to the procedure fee should be made by the surgeon, unless otherwise specified. See fee codes 94802. For Anaesthesiologist's charge, see fee codes 94800 and 98100.
- 14.13 The fee for total hip replacement includes denervation of the hip joint and adductor or abductor tenotomy.
- 14.14 When laryngoscopy and bronchoscopy are carried out as combined procedures, the physician may claim for only one of the procedures.
- 14.15 No claim should be made for bronchoscopy carried out immediately following thoracic surgery under the same anaesthetic by the same surgeon.
- 14.16 When debridement of ears under microscopy is carried out for the removal of cerumen for access purposes only, no charge should be made for the debridement.
- 14.17 The benefit for obtaining a bone graft is not to be claimed in cases of pseudoarthrosis repair, fusions or for listings in which bone grafting is included.

GENERAL PREAMBLE

15. FRACTURES

- 15.1 Open Reduction shall mean the reduction of a fracture or dislocation by an operative procedure to include the exposure of the fracture or dislocation or intramedullary means of fixation or Roger Anderson type of apparatus.
- 15.2 Closed Reduction shall mean the reduction of a fracture or dislocation by non-operative methods, including skin traction, K-wire, or Steinman's pin for balanced traction.
- 15.3 No Reduction shall mean the treatment of a fracture or dislocation where no reduction is required and shall include 42 days of care for that injury.
- 15.4 The stated fee covers full treatment including necessary after care up to 42 days by physicians of the same specialty. This includes the removal of a wire or other device when used for traction or external fixation in the treatment of a fracture or other orthopaedic procedures. A charge may be made for removal of a device used for internal fixation in addition to the procedural fee.
- 15.5 The benefit for obtaining a bone graft is not to be claimed in cases of pseudoarthrosis repair, fusion, or for listings in which bone grafting is stated to be included in the fee.
- 15.6 In multiple fractures or dislocations treated at the same sitting, the fee for the major procedure shall be the full listed fee and the other fractures or dislocations shall be at 85% of the listed fee.
- 15.7 In cases where two or more reductions (closed or open) are performed for one fracture by one or more surgeons, the full fee should be charged for the final reduction and after care. Previous reduction(s) should be charged at 85%.
- 15.8 Compound fractures or dislocations requiring extensive debridement qualify for an additional fee which is listed after the fee for open reduction of the fracture.
- 15.9 If reconstructive procedures on soft tissues are required, such services should be claimed on their own merit. Claims must be billed IC and the OR report submitted.
- 15.10 Where a patient is transferred to another surgeon for after care of a fracture or dislocation treated by "no reduction" or "closed reduction", the surgeon rendering the initial care should claim 75% of the listed fee and the surgeon rendering the subsequent care 50% except where otherwise specified. In cases involving open reduction, the percentages are 80% and 40% respectively.
- 15.11 The fee for emergency splinting of a fracture in the Emergency Department should be on the basis of the emergency room visit plus application of cast if rendered. For claiming purposes, a cast is defined as "rigid dressing, moulded to the body while pliable and hardening as it dries, to give firm support."
- 15.12 Fees for fractures or dislocations include all applications of plaster whether done during the surgery or at a later date.

GENERAL PREAMBLE

- 15.13 In the case of fractures, dislocations or minor evulsion fractures not requiring reduction, visit fees shall apply unless a specific fee is listed. For fractures listed as “visit fees” the following also apply:
- (a) when two or more fractures, each listed as “visit fees” are treated, only one visit fee should be claimed for each visit, even though more than one fracture is assessed, treated, or reassessed.
 - (b) when fractures which are listed as “visit fees” are treated along with treatment of fractures which have definite fees listed, visit fees are not payable in addition to claims for the other fracture care, and
 - (c) when fractures which are listed as “visit fees” are treated along with other non-IOP surgery, visit fees are not payable in addition to claims for surgery.

GENERAL PREAMBLE

16. SURGICAL ASSISTANT'S SERVICES**16.1 Standard Method of Billing**

- 16.1.1 Assistant fees (except specialist assistants) should be claimed by billing the listed basic fee applicable to the procedure performed and the appropriate fee for the number of time units.
- 16.1.2 Time units are calculated per operation on the basis of time spent by the physician assisting at that particular surgery. For the purpose of this calculation, time includes scrub time and time spent in the operation room. Assistant time units are calculated by allowing one unit for each 15 minutes, except for the final unit of eligible time which is equal to 15 minutes or part thereof. Units tables for convenience of billing are located in the Tables Section of this Payment Schedule. For the current time unit rate, please refer to this table.

Time units should be billed on a separate line using the basic procedural fee code as the first 5 digits and adding 1, for a total of six digits in the time units fee code.

- 16.1.3 Claims for assistants' fees for surgical procedures with no listed assistant basic rate are required to be submitted IC, and must include the reason why, based on medical necessity, an assistant was required.
- 16.1.4 When multiple or bilateral surgical procedures are performed during the same anaesthetic, the assistant is entitled to claim the basic fee code for the major procedure only, plus any applicable add-ons, plus total time units. Total time units claimed should be billed under the time unit code for the major procedure only.
- 16.1.5 When more than one assistant is required for a surgical procedure, the fee for the second assistant is calculated in the same manner as the fee for the first assistant.
- 16.1.6 Where the attendance of a physician is requested by the patient's other medical attendants for the sole purpose of monitoring or special supportive care, and when the physician is in constant attendance, the benefit shall be 3 time units plus time. (Fee code 90020).
- 16.1.7 When an anaesthetic has begun and the operation is cancelled prior to commencement of surgery, the assistant who has scrubbed but is not required to do more, should claim using fee code 90040 plus time.

Note 1: If the operation is cancelled after surgery has commenced, the performed procedural basic plus time units will apply.

Note 2: If the procedure is cancelled prior to the induction of anaesthesia and the assistant is scrubbed, an SHV only may be claimed.

16.2 Dedicated Time Method of Billing

- 16.2.1 Physicians have the option of billing for surgical assistant's services according to either the Standard method described above or the Dedicated Time method.

GENERAL PREAMBLE

16.2.2 Dedicated time is defined as time spent in hospital for the provision of requested surgical assistant's services. Payment for dedicated time represents payment for all insured services rendered during the dedicated time. The period of time claimed as dedicated time must not be interrupted in order to bill for insured services under other methods of billing.

16.2.3 No other insured services may be billed to MCP during the time claimed as dedicated time.

16.2.4 Actual time spent assisting at non-MCP insured procedures, e.g. WHSCC or out-of-province patients must be subtracted from the time claimed as dedicated time.

16.2.5 Dedicated time units are equal to 15 minutes, except for the final unit of eligible time which is equal to 15 minutes or part thereof. Units tables for convenience of billing are located in the Table Section of this Payment Schedule. For the current time unit rate, please refer to this table.

Note: Instructions with respect to preparation and submission of claims for surgical assistant's services using the Dedicated Time method of billing are included in the MCP Physician's Information Manual.

16.2.6 When a physician has set aside time to provide assistant's services and is given less than 18 hours notice that the scheduled surgical list has been cancelled, the physician may claim payment of time units. The number of units payable is based on the scheduled start time for the surgical list and ends when the physician resumes working. A maximum of 12 units of dedicated surgical assist time units may be claimed. The physician must identify on the claim that the fee claimed is the result of a cancelled surgical list.

16.3 **Specialist Assistant**

When two surgeons are working together at a procedure for which neither a team fee nor other method of claiming is set out in the Schedule, one surgeon should be identified as the operating surgeon and claim accordingly; the surgeon which is assisting should be identified as such and claim the assistant's benefit. Certain procedures, because of their difficulty or complexity, require the services of a specialist assistant and a list of eligible procedures can be obtained from the MCP **Manager of Claims Operations**. If a claim is made for a procedure not on this list, it is subject to internal review and/or adjudication by the Medical Advisory Committee. The specialist assistant rate is not payable on the sole basis that the assistant is a specialist; the criteria of difficulty and/or complexity must also be met. The specialist assist rate is 75% of the primary surgeon's fee and these claims must be submitted IC.

16.4 **Premiums**

Premiums are payable for non-elective, non-scheduled surgical procedures which are performed outside of normal working hours. See Section 18.

GENERAL PREAMBLE

17. ANAESTHESIOLOGY SERVICES

- 17.1 The tariffs listed are for all types of anaesthesia and cover the fees for professional services including pre-anaesthetic examination (excluding Pre-anaesthetic Clinics) and post-anaesthetic follow up and all immediate supportive measures, but do not include the cost of material used.
- 17.2 Anaesthetic fees should be claimed by billing the listed basic fee (for the major procedure performed) and the appropriate fee for the number of time units. When multiple or bilateral surgical procedures are done during the same anaesthetic, only one basic fee is payable.
- 17.3 Anaesthesia basic fees are listed as unit values. Anaesthesia basic fees must be claimed as dollar amounts and not as unit values. The amounts payable for each unit value are located in the Tables Section of this Payment Schedule.
- 17.4 Anaesthetic time begins when the Anaesthesiologist is first in attendance with the patient for the purpose of creating an anaesthetic state and ends when they are no longer in personal attendance.
- 17.4.1 Anaesthesia time units are calculated by allowing one unit for each 15 minutes, except for the final unit of eligible time which is equal to 15 minutes or part thereof.
- (a) Time units greater than one hour but less than two hours are payable at double the listed time unit rate. A units table for convenience of billing is located in the Tables Section of this Payment Schedule.
- (b) Time units greater than two hours are payable at triple the listed time unit rate for all cases, regardless of the basic fee amount.
- 17.4.2 Time units should be billed on a separate line using the basic procedural fee code as the first 5 digits and adding '1' as the sixth digit in the time units fee code.
- 17.5 In most cases, additional fees are not payable. However, any codes listed as "extra" or "add", and having a listing in the anaesthesiology columns are billable in addition to the "basic". See also "Additional Fees Payable" below. In addition to these service in capacity 3, and any service rendered in capacity 0 that are not a routine component of the anaesthesiology service are also payable.
- 17.6 **Epidural Anaesthesia:**
- (a) **Obstetrical Cases**
- Epidural for Labour** – Claim using basic fee code 80042. For the maintenance, claim using fee code 80044. A maximum of 12 units of 80044 is payable. Time for the (routine) delivery may be claimed using 800401. A second basic is not payable except in the case of Caesarean Sections and Operative Deliveries which are considered to be separate procedures.
- Epidural for Post-delivery Pain** – This is payable in addition to Epidural for Labour and the delivery "time". To bill this, use fee code 54134 only (an additional basic is not payable). However, if the epidural was set up for post-delivery pain only, use both codes 54132 and 54134.

GENERAL PREAMBLE

- (b) **Epidural for Non-Obstetrical Cases** – Bill using fee code 54132. Bill for the maintenance using fee code 54134. A maximum of 12 units of the maintenance (code 54134) is payable per 24-hour period.

17.7 Cancelled Surgery:

- (a) When an anaesthetic has begun and the operation is cancelled due to a complication prior to the commencement of surgery, the Anaesthesiologist should claim fee code 90040 plus time.
- (b) If the operation is cancelled after the surgery has commenced, the performed procedural basic fee plus time units will apply.

17.8 Anaesthesiology Consults:

17.8.1 Generally, consultations are not payable in addition to anaesthetic fees.

17.8.2 However, an anaesthesiology consultation is payable before a procedure if the consultation is formally requested by a physician in respect of a complicated patient considered for anaesthetic. Claims for anaesthesiology consultations must be submitted IC supporting the need for the service claimed.

17.8.3 Routine pre-anaesthetic evaluation of the patient at the request of a physician does not qualify as a consultation. Consultation fee codes may not be claimed by an Anaesthesiologist in respect of patients assessed in an organized pre-anaesthetic clinic, regardless of referral.

17.9 Additional Fee Codes Billable in Capacity 3:

When an Anaesthesiologist administers an anaesthetic to a patient in the following situations, an additional fee may be claimed as indicated. These fees should be claimed in Capacity 3.

- (a) Anaesthetic wake-up test – This is payable when the patient under general anaesthetic is awakened during a procedure to assess neurological function, following which the anaesthesia is recommended. Use fee code 90014.
- (b) Fiberoptic intubation – This is payable only when the regular intubation is impossible and is not payable as a routine replacement. Use fee code 90016.
- (c) One lung anaesthesia – This is payable when double-lumen endotracheal tube is placed which permits selective ventilation of either lung as required by the thoracic procedure. Use fee code 90018.
- (d) Children under the age of 1. Use fee code 90024.
- (e) Patients over the age of 70. Use fee code 90026.
- (f) Patients who are in a constant life threatening condition. Use fee code 90028.
- (g) Patients who receive anaesthetic in the prone or sitting positions. Use fee code 90030.
- (h) Patients who weigh less than 5 kgs. Use fee code 90032.

GENERAL PREAMBLE

- (i) Controlled hypotension – This technique is used in conjunction with anaesthesia to reduce the patient’s blood pressure to a level at least 25% below the normal for that patient. Bill using fee code 90034.
 - (j) Malignant hyperthermia set up and management – This applies when a patient is known to have malignant hyperthermia or there is a strong suspicion of susceptibility and the Anaesthesiologist requires full malignant hyperthermia set up and management. Bill using fee code 90036. This add-on does not apply with fee code 90144.
 - (k) Anaesthesiologist management for the emergency relief of acute upper airway (above the carina) obstruction, excluding choanal atresia. Use fee code 90038.
 - (l) Patient with body mass index (BMI) greater than 40 who receives general anaesthesia. Use fee code 90042.
- 17.10 In special cases where the services of more than one Anaesthesiologist are deemed necessary in the interest of the patient, the basic fee shall be increased by 50% of that listed for the procedure; each Anaesthesiologist to be entitled to one half of the total basic benefit. Each Anaesthesiologist will claim for the anaesthesia time they are present. Claims must be submitted IC. “Additional codes billable” are each payable at 100% of the listed rate to each Anaesthesiologist.
- 17.11 Where one Anaesthesiologist starts a procedure and is replaced by another part way through a surgical procedure or delivery, the first Anaesthesiologist should claim the appropriate basic fee plus time units for the time present. The second Anaesthesiologist may claim for their time units only. Each Anaesthesiologist should state on their claim which part of the anaesthetic is being claimed as well as the time begun and completed by them.
- 17.12 In procedures where no fee is listed, or where IC is indicated, the basic portion of the calculated fee will be the same as listed for a comparable procedure considering region and modifying conditions or techniques.
- 17.13 When a by-pass pump, with or without an oxygenator, and with or without hypothermia, is employed in conjunction with an anaesthetic, the anaesthetic “Basic Value” shall be the equivalent of 28 time units. To compensate for variations in anaesthesiology practice, special respiratory intensive care or detention for the purpose of intensive treatment of other types should be billed separately under the appropriate headings.
- 17.14 When a physician administers an anaesthetic and/or medication prior to, during, or immediately after the procedure(s) which the physician performs on the same patient, the procedure(s) only should be claimed. However, when a physician administers a retrobulbar, stellate ganglion, femoral, sciatic, ilioinguinal, iliohypogastric, ulnar, median, radial block for local anaesthetic purposes, or epidural for delivery block, in addition to performing the procedure, a claim may be made in addition to the procedure fee, using fee code 54150.
- 17.15 Where the attendance of the Anaesthesiologist is requested by the patient’s other medical attendants for monitoring, special care, or for immediate availability and where the Anaesthesiologist is in constant attendance, bill using fee code 90020 plus time. The claim must be submitted IC. This does not apply to waiting time for scheduled procedures or to the normal preparation time for emergency procedures.
-

GENERAL PREAMBLE

- 17.16 Where unusual detention with the patient before or after anaesthesia is essential for the safety and welfare of the patient, the necessary time will be valued on the same basis as indicated for the anaesthetic time. For detention not associated with anaesthesia, detention rates and criteria apply.
- 17.17 When hypothermia is used by the Anaesthesiologist in procedures not specifically identified as requiring hypothermia, the basic value is 25 units. This basic value replaces the basic value listed in the schedule for the procedure. The claim must be submitted IC.
- 17.18 Anaesthesia time units may not be claimed by the same Anaesthesiologist for rendering anaesthesia or other time-reimbursed services to more than one patient at the same time, with the exception of fee codes 54068, 54134, 54162 and 80044.
- 17.19 Premiums are payable for non-elective, non-scheduled surgical procedures which are performed outside of normal working hours.

GENERAL PREAMBLE

18. PREMIUMS**18.1 General Premium Rates**

- (a) Where a premium fee is applicable based on the time the service is rendered, a starting time indicator for that service must appear in the patient's record.
- (b) Premiums are not payable for:
 - i. patients seen for convenience by the physician during a special visit,
 - ii. visits on regular rounds to registered bed patients,
 - iii. admission assessments of patients who have been admitted to hospital on an elective basis, regardless of the time performed, and
 - iv. maintenance or monitoring procedural fee codes.
- (c) Statutory Holidays are as listed in the appropriate MCP Newsletter for that year and do not include additional Civic Holidays (e.g. Regatta Day). Premiums may be claimed for services provided on the ACTUAL Statutory Holiday but not on a day held in lieu of the holiday.

18.2 Special Visit Premiums

(Special visit premiums applicable to Radiologists and Nuclear Medicine Specialists are described in Section 11 and 12 of this Preamble):

- (a) A special visit is one initiated by a patient or the patient's representative where the physician is required to travel from one location to another to see the patient. The type of premium to be claimed is dependent on where the service is provided, the time of day, and what day the service is rendered.
- (b) A special visit may also involve an emergency call with sacrifice of office hours. The benefits for this type of special visit applies in a situation where the demands of the patient or the physician's interpretation of the patient's condition are such that the physician responds immediately.
- (c) A special visit premium will also be payable for special in-patient visits requested by the hospital for which no fee is otherwise payable.
- (d) Only one special visit premium may be claimed for the same patient, same visit.
- (e) Special visit premiums are to be claimed as separate line items or on the same line with the visit claim. Separate line items apply when no visit is payable or when SHV applies.

18.2.1 Home Visit Premiums

This term applies to all physicians and home visits except home visit made by **Family Physicians**. Home visits and "extra patient seen" during a home visit by **Family Physicians** are not eligible for the additional claim of a premium as the visit fee listed represents the total fee payable.

For home visits made by specialists, an extra patient seen warrants a premium only if the patient seen was ill enough to warrant a special visit themselves.

GENERAL PREAMBLE

18.2.2 Office (or Physician's Residence) Visit Premiums

A special visit premium is payable for the first patient seen when the physician makes a special trip to the office or to the physician's own home from another site (see definition of "Site of Insured Service" in Section 5.1 of this Preamble) to see a patient outside of normal office hours. Subsequent patients seen during the same visit do not qualify for an additional premium claim.

If a regular clinic is held on a Saturday, Sunday, or Statutory Holiday, special visit rates do not apply.

18.2.3 Hospital OPD/Emergency and In-Patient Visit Premiums

A premium is payable for the first patient seen when the physician makes a special trip to the hospital to see the patient, provided that the visit has been specifically requested by the hospital staff or another physician because of the patient's condition. Subsequent patients seen during the same visit warrant an "extra patient seen" premium only if the physician is requested by the hospital staff or another physician to see those additional patients after arriving for the visit. A special visit premium is payable for special in-patient visits requested by the hospital staff for which no fee is otherwise payable.

Premiums payable to physicians who are providing dedicated on-site Emergency Department coverage, and billing for services rendered on a fee-for-service basis, are listed as premium codes 80 to 89.

18.3 Procedural Premiums (For deliveries see 18.4 below)

(a) All Surgeons, Anaesthesiologists, Surgical Assistants who participate in procedures that are non-elective, unscheduled and which either require the services of an Anaesthesiologist, or are performed using one of the regional nerve blocks specified in fee code 54150 for local anaesthetic purposes, are eligible for payment of a premium when the procedures commence between 6:00 p.m. and 7:00 a.m., or on Saturdays, Sundays, and Statutory Holidays.

(b) The procedural premium code and amount must be billed on the same line as the procedural fee code and, where applicable, the time units fee code.

18.3.1 Surgeons' Procedural Premiums:

(a) For procedures that qualify and commence between 6:00 p.m. and midnight, or on Saturdays, Sundays, or Statutory Holidays:

Claim 30% of each procedure billed, using premium code 01.

(b) For procedures that qualify and commence between 12:00 a.m. and 7:00 a.m.:

Claim 50% of each procedure billed, using premium code 03.

18.3.2 Anaesthesiologists' Procedural Premiums:

(a) For procedure that qualify and commence between 6:00 p.m. and midnight, or on Saturdays, Sundays, or Statutory Holidays:

Claim 46% of the basic and time unit fees billed, using premium code 02.

(b) For procedures that qualify and commence between 12:00 a.m. and 7:00 a.m.:

Claim 50% of the basic and time unit fees billed, using premium code 03.

GENERAL PREAMBLE

18.3.3 Surgical Assistants' Procedural Premiums:

(a) For procedures that qualify and commence between 6:00 p.m. and midnight, or on Saturdays, Sundays, or Statutory Holidays:

Claim 30% of each assistant's fee payable, using premium code 01.

(b) For procedures that qualify and commence between 12:00 a.m. and 7:00 a.m.:

Claim 50% of each assistant's fee payable, using premium code 03.

18.4 Delivery Premiums

18.4.1 Vaginal deliveries, Caesarean sections, and other operative deliveries performed after hours qualify for after-hours surgical procedure premiums.

18.4.2 For the delivering physician and surgical assistant, procedure premium code 01 applies from 6:00 p.m. to midnight, or on Saturdays, Sundays, and Statutory Holidays. For the delivering physician and surgical assistant, procedure premium code 03 applies any night between 12:00 a.m. and 7:00 a.m.

18.4.3 For the Anaesthesiologist, procedure premium code 02 applies from 6:00 p.m. to midnight, or on Saturdays, Sundays, and Statutory Holidays. For the Anaesthesiologist, procedure premium code 03 applies any night between 12:00 a.m. and 7:00 a.m.

18.4.4 Vaginal deliveries, Caesarean sections and other operative deliveries performed at times other than those specified above do not qualify for a premium.

GENERAL PREAMBLE

19. SESSIONAL ARRANGEMENTS**19.1 General Policy on Sessional Arrangements**

19.1.1 Sessional payment is for clinical time spent rendering insured services in lieu of fee-for-service claims for the services rendered during that time. Administrative meetings/annual program reviews are not eligible to be claimed as a sessional arrangement.

Physician's travel time does not constitute "time spent" in a sessional arrangement.

19.1.2 Only physicians eligible to bill fee-for-service are allowed to bill for sessional payment.

19.1.3 No fee-for-service claims may be submitted for insured services rendered while on Sessional duty. Any exceptions to this rule are listed under the descriptions of the individual sessional arrangements.

19.1.4 Claims for the sessional arrangements must be submitted as described in the Physician's Information Manual.

19.1.5 Sessional Approval Process

(a) Sessional arrangements require individual pre-approval from the Department of Health and Community Services and must be requested in writing to the Administrator of the institution requiring the sessional service. The written request should include information about the nature of the insured service to be provided, anticipated patient volume, and clinic frequency.

(b) To qualify for approval as a sessional arrangement, insured physician services must be provided in a publicly funded facility; either:

i. A multidisciplinary clinic which is dedicated to offering **family medicine** or specialist service to patients with chronic/complex problems.

OR

ii. A correctional institution.

19.2 Organized Sessional Clinics

19.2.1 A claim for sessional payment should represent the time "set aside" or dedicated by a physician for sessional services.

19.2.2 One session should represent a "committed morning, afternoon, or evening."

19.2.3 On average, a claim for a half-day session should equate to three hours of service.

19.2.4 Physicians have the option to bill either fee-for-service or sessional for the duration of a clinic.

GENERAL PREAMBLE

19.2.5 No fee-for-service billings should occur during the time dedicated to the session, at or outside of the sessional arrangement. However, emergency services that result from a physician's on-call commitment, which occur during "committed sessional time", may be submitted IC for consideration for payment. Physicians may bill patients for non-insured services, or services provided to WHSCC, or out-of-province patients during the time period that a sessional is claimed.

19.2.6 The rates listed are for a half day and represent a committed morning, afternoon, or evening in an approved organized sessional clinic.

Family Medicine	\$566.53 per half day
Specialist	\$659.26 per half day

19.3 On-Site Emergency Department Coverage

19.3.1 Fee-for-service physicians who provide dedicated on-site emergency department coverage at designated facilities are eligible for remuneration at an hourly sessional rate. Currently designated facilities are listed in Appendix A.

19.3.2 If billing as sessional, no fee-for service billings should occur during the time dedicated to a sessional, at or outside the sessional arrangement, with the exception of out-of-province, out-of-country, and WHSCC claims. Sessional is intended to cover time spent in the facility.

19.3.3 Physicians have the option to bill either fee-for-service or sessional for the duration of a shift.

19.4 Dedicated On-Site 24-Hour ICU Sessional Coverage

19.4.1 This sessional is for the claiming of dedicated, on-site, ICU services at facilities designated by the **HCS**.

19.4.2 The facilities designated for the claiming of this sessional arrangement are:

- (a) General Hospital, St. John's
- (b) St. Clare's Mercy Hospital, St. John's

19.4.3 Payment of the 24-hour sessional for each facility is based on the number of designated beds multiplied by the applicable daily bed rate.

19.4.4 MCP must officially be notified if and when the number of beds in a unit changes.

19.4.5 For claiming purposes, the 24-hour sessional starts at 8:00 a.m.

19.4.6 If, at any time, during a 24-hour sessional period, a bed is occupied by a non-Canadian, out-of-province, or third party patient, the claim for payment should be reduced by the value of the daily bed rate multiplied by the number of such patients.

GENERAL PREAMBLE

20. CATEGORY 'B' EMERGENCY DEPARTMENT COVERAGE BY FEE-FOR-SERVICE FAMILY PHYSICIANS

- 20.1 Fee-for-service **Family Physicians** who are scheduled to immediately respond to the emergency needs for a Category 'B' designated facility, that provides 24-hour emergency services, are eligible to bill an hourly fee.
- 20.2 Eligible facilities are listed in Appendix B and include **HCS** facilities designated as either an Acute Care Facility or Health Care Centre that require 24-hour primary care emergency services, excluding those facilities listed in Appendix A.
- 20.3 Daytime coverage on weekdays
An hourly fee of **\$56.65** must be billed for daytime coverage, 8:00 a.m. to 6:00 p.m. Monday to Friday. During that time fee-for-service **Family Physicians** may also bill for individual insured services using the appropriate fee code as listed in this payment schedule.
- After hours, weekend and statutory holiday coverage
Fee-for-service **Family Physicians** may bill an all-inclusive hourly rate of **\$78.84** for after-hours coverage from 6:00 p.m. to 8:00 a.m. Monday to Friday, all day Saturday, all day Sunday, and all day on RHA designated statutory holidays. If the hourly rate of **\$78.84** is billed, no fee-for-service claims are payable. Alternatively, they may bill the hourly rate of **\$56.65** plus fee-for-service billings. The method of billing is at the physician's discretion but must apply for the entire shift or period of ED coverage provided.
- Shift definition
A shift is a period of continuous ED coverage by a physician. For example, when a physician provides weekend coverage from 6:00 p.m. on Friday to 8:00 a.m. on Monday that period is considered a single shift for billing purposes. A shift must be of at least eight hours duration; it cannot be divided into shorter periods for billing purposes.
- 20.4 Instructions with respect to preparation and submission of claims for this service are included in the MCP Physician's Information Manual.

GENERAL PREAMBLE

21. LONG TERM CARE FACILITY COVERAGE BY FAMILY PHYSICIAN

- 21.1 **Family Physicians** who provide clinical services and coverage to **HCS** designated long term care facilities that have long term care beds are eligible for payments of a per diem fee.
- 21.2 To qualify for claiming the per diem fee, physicians must provide comprehensive 24-hour coverage for all medically necessary services to the facility.
- 21.3 The fee for each facility is unique, based on the number of registered beds in the facility. Currently, designated facilities, the applicable facility numbers, and rates are listed in Appendix C.
- 21.4 Instructions with respect to preparation and submission of claims for this service are included in the MCP Physician's Information Manual.
- 21.5 Direct patient care visit(s) to these facilities can be claimed on a fee-for-service basis and paid in addition to the per diem fee. These services must be claimed using the dedicated nursing home visit codes for **Family Medicine**. The home's facility number must be entered on claims for these services.

GENERAL PREAMBLE

22. RURAL FAMILY PHYSICIAN HOSPITAL PREMIUM

- 22.1 During claims processing, MCP automatically applies a 20% premium to claims submitted by **Family Physicians** for specific hospital fee codes in Capacities 0 and 3. It is not necessary to claim this premium.
- 22.2 The premium is applied to specific services rendered in the following approved facilities:

Facility Number	Facility Name
0051	Baie Verte Peninsula Health Centre, Baie Verte
0141	Dr. Charles S. Curtis Memorial Hospital, St. Anthony
0159	Captain William Jackman Memorial Hospital, Labrador City
0167	Labrador Health Centre, Happy Valley-Goose Bay
0183	Sir Thomas Roddick Hospital, Stephenville
0191	Dr. C.L. LeGrow Health Centre, Port aux Basques
0221	Notre Dame Bay Memorial Health Centre, Twillingate
0230	Carbonear General Hospital, Carbonear
0248	Dr. G.B. Cross Memorial Hospital, Clarenville
0299	Dr. Y.K. Jeon Health Centre, Brookfield
0302	Burin Peninsula Health Care Centre, Burin
0311	Connaigre Peninsula Health Care Centre, Harbour Breton
0329	Fogo Island Hospital, Fogo
0337	Dr. A.A. Wilkinson Memorial Health Centre, Old Perlican
0345	Bonavista Community Health Centre, Bonavista
0353	Dr. Walter Templeman Community Health Centre, Bell Island
0388	Calder Health Care Centre, Burgeo
0396	Rufus Guincharde Health Care Centre, Port Saunders
0418	Placentia Health Centre, Placentia
0426	Green Bay Community Health Centre, Springdale
0434	A.M. Guy Memorial Health Centre, Buchans
0442	Bonne Bay Health Centre, Bonne Bay

GENERAL PREAMBLE

22.3 The premium is applied to the following approved fee codes during claims processing:

Hospital Visit Premiums	70-99
Hospital Visits	301-481
Diagnostic & Therapeutic Services	540000-551561
Obstetrical Procedures	800020-810381
Surgical Dental Procedures	840400-849301
Surgical Procedures	900080-994921
Procedure Premiums	01-03

GENERAL PREAMBLE

23. PHYSICIAN REGISTRATION

- 23.1 All physicians receiving funding from MCP for clinical services provided must be registered with MCP through completion of a Provider Registration Form.
- 23.2 Additions to, or changes in location of practice, either full or part-time require notification to MCP prior to the changes being effective.

24. LOCUM COVERAGE

Written documentation of locum practice/services is required for all physicians. Contact MCP for current policy and forms.

APPROVED CATEGORY 'A' FACILITIES
24-HOUR ON-SITE EMERGENCY DEPARTMENT COVERAGE

Hospital Number	Hospital Name
0141	Dr. Charles S. Curtis Memorial Hospital, St. Anthony
0159	Capt. Wm. Jackman Memorial Hospital, Labrador City
0167	Labrador Health Centre, Happy Valley-Goose Bay
0175	Western Memorial Regional Hospital, Corner Brook
0183	Sir Thomas Roddick Hospital, Stephenville
0205	James Paton Memorial Hospital, Gander
0213	Central Newfoundland Regional Health Centre, Grand Falls-Windsor
0230	Carbonear General Hospital, Carbonear
0248	Dr. G.B. Cross Memorial Hospital, Clarenville
0256	General Hospital, Health Sciences Centre, St. John's
0264	St. Clare's Mercy Hospital, St. John's
0281	Janeway Children's Health & Rehabilitation Centre, St. John's
0302	Burin Peninsula Health Care Centre, Burin

APPROVED CATEGORY 'B' FACILITIES
24-HOUR EMERGENCY DEPARTMENT COVERAGE

Facility Number	Facility Number
0016	Grand Bank Community Health Centre, Grand Bank
0022	U.S. Memorial Health Centre, St. Lawrence
0051	Baie Verte Peninsula Health Centre, Baie Verte
0191	Dr. C.L. Legrow Health Centre, Port aux Basques
0200	North Haven Emergency Centre, Lewisporte
0221	Notre Dame Memorial Health Centre, Twillingate
0299	Dr. Y.K. Jeon Health Centre, Brookfield
0311	Connaigre Peninsula Health Care Centre, Harbour Breton
0329	Fogo Island Hospital, Fogo
0337	Dr. A.A. Wilkinson Memorial Health Centre, Old Perlican
0345	Bonavista Community Health Centre, Bonavista
0353	Dr. Walter Templeman Community Health Centre, Bell Island
0388	Calder Health Care Centre, Burgeo
0396	Rufus Guinchard Health Care Centre, Port Saunders
0400	Dr. William Newhook Community Health Centre, Whitbourne
0418	Placentia Health Centre, Placentia
0426	Green Bay Community Health Centre, Springdale
0434	A.M. Guy Memorial Health Centre, Buchans
0442	Bonne Bay Health Centre, Bonne Bay
0451	Dr. Hugh Twomey Health Care Centre, Botwood

**HCS DESIGNATED LONG TERM CARE FACILITIES
WITH LONG TERM BEDS**

Facility Number	Facility Name	Rate
0022	U.S Memorial Health Centre, St. Lawrence	\$68.64
0051	Baie Verte Peninsula Health Centre, Baie Verte	\$33.44
0159	Labrador West Health Centre, Labrador City	\$21.12
0191	Dr. Charles Legrow Health Centre, Port aux Basques	\$52.80
0200	Lewisporte Health Centre, Lewisporte	\$110.88
0221	Notre Dame Bay Health Centre, Twillingate	\$56.32
0311	Connaigre Peninsula Health Centre, Harbour Breton	\$35.20
0329	Fogo Island Health Centre, Fogo Island	\$19.36
0353	Dr. Walter Templeman Health Care Centre, Bell Island	\$26.40
0388	Calder Health Centre, Burgeo	\$31.68
0396	Rufus Guinchard Health Centre, Port Saunders	\$38.72
0418	Placentia Health Centre, Placentia	\$132.00
0426	Valley Vista Senior Citizen's Home, Springdale	\$137.28
0434	A.M. Guy Memorial Health Centre, Buchans	\$36.96
0442	Bonne Bay Health Centre, Norris Point	\$24.64
0451	Dr. Hugh Twomey Health Care Centre, Botwood	\$176.00
0800	Glenbrook Lodge, St. John's	\$174.24
0801	Caribou Memorial Veteran's Pavilion, St. John's	\$95.04
0802	St. Patrick's Mercy Home, St. John's	\$367.84
0804	Saint Luke's Home, St. John's	\$195.36
0806	Agnes Pratt Home, St. John's	\$230.56
0810	Pleasant View Towers, St. John's	\$806.08
0815	Carbonear Long Term Care, Carbonear	\$401.28
0818	Blue Crest Interfaith Home, Grand Bank	\$105.60
0819	Dr. Albert O'Mahony Memorial Manor, Clarenville	\$77.44
0820	Lakeside Homes, Gander	\$179.52
0821	Gander Long Term Care Home, Gander	\$105.60

**HCS DESIGNATED LONG TERM CARE FACILITIES
WITH LONG TERM BEDS**

0822	Carmelite House, Grand Falls-Windsor	\$112.64
0823	Grand Falls-Windsor Long Term Care, Grand Falls-Windsor	\$105.60
0825	Corner Brook Long Term Care and Protective Care Residence, Corner Brook	\$512.16
0827	Western Long Term Care Home, Corner Brook	\$184.80
0828	Bay St. George Senior Citizens' Home, Stephenville Crossing	\$198.88
0829	Bonnews Lodge, Badger's Quay	\$79.20
0831	Corner Brook Community Health Centre, Corner Brook	\$79.20
0832	John M. Gray Centre, St. Anthony	\$95.04
0834	Labrador South Health Centre, Forteau	\$28.16
0836	Happy Valley-Goose Bay Long Term Care Home, Happy Valley-Goose Bay	\$121.44
0837	Clarenville Protective Care Residence, Clarenville	\$21.12
0839	Golden Heights Manor, Bonavista	\$123.20
0841	Bonavista Bungalows Protective Community Residence, Bonavista	\$21.12

IMMUNIZATION OF DESIGNATED TARGET POPULATIONS

Immunization of target populations designated by HCS are MCP insured services. Rules for billing these services are included in Section 9.4 of the Preamble.

The contacting of target population patients to remind them of the availability of the immunization will not be viewed by MCP as solicitation.

IMMUNIZATION AGAINST MEASLES, MUMPS AND REBELLA (MMR)

The target population designated by HCS for immunization against measles, mumps, and rubella is limited to the categories of adult beneficiaries outlined in Recommendations for Immunization with MMR for Adults (p.10) as well as Measles Vaccination for Travelers (p. 13) of [Measles: Information for Healthcare Providers](#). Please note that children and those requiring MMR for post-exposure prophylaxis are not included in the designated target population.

IMMUNIZATION AGAINST TETANUS, DIPHTHERIA, AND PERTUSSIS

The target population designated by HCS for immunization against pertussis is limited to the following categories of beneficiaries:

- Those MCP beneficiaries for whom ten years have passed since receiving a pertussis-containing vaccine in adolescence. One booster dose is payable for each adult requiring it.

The target population designated by HCS for immunization against tetanus is limited to the following categories of beneficiaries:

- Those adults greater than 18 years of age for whom ten years have passed since receiving vaccination against tetanus. Immunization is recommended every ten years.
- Those adults great than 18 years of age requiring active immunization with a tetanus-containing vaccine for wound management. Please see the following document for recommendations for tetanus immunization in wound management: [Immunization Programs for High Risk Groups](#).

IMMUNIZATION AGAINST PNEUMOCOCCAL DISEASE WITH 20-VALENT (PNEU-C-20) CONJUGATE VACCINE

The target population designated by HCS for immunization against pneumococcal disease with Pneu-C-20 is limited to the following categories of beneficiaries:

- All adults 65 years of age and older are eligible for one dose of Pneu-C-20.
- Adults 18 years of age and older with medical or environmental risk factors resulting in an increased risk of invasive pneumococcal disease (IPD) are eligible for one dose of Pneu-C-20. For further information on conditions resulting in increased risk of IPD, please see [Provincial-Immunization-Manual-pneumococcal-conjugate-vaccine-section.pdf](#).

IMMUNIZATION OF DESIGNATED TARGET POPULATIONS

- **Adults who have received a hematopoietic stem cell transplant should be immunized with Pneu-C-20 following completion of the transplant and upon agreement with their transplant specialist.**

IMMUNIZATION AGAINST SHINGLES

The target population designated by HCS for immunization against shingles is limited to the following categories of beneficiaries. Eligible beneficiaries should receive two doses of shingles vaccine spaced two to six months apart for optimal protection.

- **Adults 50 years of age and older.**
- **Adults 18-49 years of age with immunocompromising conditions. For a list of eligible immunocompromising conditions, please see [Provincial-Immunization-Manual-Shingles-Program.pdf](#).**

IMMUNIZATION AGAINST INFLUENZA

Immunization against influenza is now available universally.

NON-INSURED SERVICES LIST

Services which are not insured services under the Medical Care Insurance Act are defined in the Medical Care Insurance Insured Services Regulations. The following list represents current MCP policy with respect to non-insured services based on the Medical Care Insurance Insured Services Regulations. Inquiries relating to the insurability of a specific service not listed in the Insured Services Regulations or the Medical Payment Schedule should be directed to the office of the **Assistant Director of Medical Services**.

- health examinations, including pre-employment, pre-school, periodic and insurance physicals,
- vaccination of persons who are not part of target populations designated by the **HCS**. (See Appendix D),
- visits for renewal of prescription only,
- x-ray, laboratory or other diagnostic and therapeutic services provided outside a hospital, unless approved by **HCS**,
- experimental treatments and procedures,
- services associated with clinical trials,
- laser surgery for vascular lesions not listed in existing **HCS** policy,
- services associated with hair transplantation,
- injection of asymptomatic superficial veins,
- epilation,
- excision of redundant skin for elimination of wrinkles,
- excision or destruction of tattoos, and
- surgery, including laser surgery, for correction of refractive errors.

SCAR REVISION

1. Trauma Scars

(a) Neck or Face:

- i. Includes ears and non-hair bearing areas of the scalp.
- ii. Repair of all such scars is an insured benefit, except for scars resulting from previous surgery to alter appearance that was not originally a benefit.
- iii. Repair procedures will depend upon the lesion but may include excision, revision, dermabrasion, etc. Rhytidectomy procedures for cosmetic reasons, however, are not insured benefits.

(b) Scars in other Anatomical Areas:

- i. Repair of scars which interfere with function or which are significantly symptomatic (pain, ulceration, etc.) is an insured benefit.
- ii. Scars with no significant symptoms or functional interference:
 - Repair is an insured benefit if such a repair is part of a pre-planned post-traumatic (including post-surgical) staged process.
 - Other post-traumatic scar revision is not an insured benefit.
 - Scar revision should not be claimed when excision of a scar is the method of gaining access to the surgical site of the major procedure.

Scar revision codes (90336 to 90348) should be used when the method employed involves cutting of tissue and closure with sutures. Dermabrasion fee codes (90576 to 90584) should be used in cases involving dermabrasion or laser surgery.

2. Keloids

(a) Head or Neck:

- i. The repair of all such keloids is an insured benefit.
- ii. Repair procedures may include excision, injection, dermabrasion or planing.

(b) Excision of keloids in other areas:

- i. Not an insured benefit unless significantly symptomatic (pain, ulceration, etc.) or there is a functional impairment.

Scar revision codes (90336 to 90348) should be used when the method employed involves cutting of tissues and closure with sutures. Dermabrasion fee codes (90576 to 90584) should be used in cases involving dermabrasion or laser surgery.

HYPERBARIC OXYGEN THERAPY

The following indications are approved uses of hyperbaric oxygen therapy as defined by the Hyperbaric Oxygen Therapy Committee of the Undersea and Hyperbaric Medical Society. They are insured by and billable to MCP:

- Air or Gas Embolism
- Carbon Monoxide Poisoning
 Carbon Monoxide Poisoning Complicated by Cyanide Poisoning
- Clostridial Myositis and Myonecrosis (Gas Gangrene)
- Crush Injury, Compartment Syndrome, and other Acute Traumatic Ischemias
- Decompression Sickness
- Enhancement of Healing in Selected Problems Wounds
- Exceptional Blood Loss (Anemia)
- Intracranial Abscess
- Necrotizing Soft Tissue Infections
- Osteomyelitis (Refractory)
- Delayed Radiation Injury (Soft Tissue and Bony Necrosis)
- Skin Grafts and Flaps (Compromised)
- Thermal Burns

CONSULTATIONS AND VISITS

SPECIAL VISIT PREMIUMS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP	Spec.
Office (or visit to Physician’s Residence) - see applicable Preamble section			
<u>Special visit to the office premiums</u> - (1 st patient seen) – to be billed in addition to applicable office visit fee code.			
50	Monday to Friday between 8:00 a.m. and 6:00 p.m. outside regular scheduled office hours	25.34	17.90
52	Saturdays , Sundays or Statutory Holidays, or 6:00 p.m. to midnight	31.63	35.80
53	Patient initiated non-elective (special) service rendered between midnight and 8:00 a.m. ...	37.91	53.76
Notes:			
1. Special visit premiums are <u>not</u> payable in addition to the following services:			
- visit for well-baby care			
- detention			
2. <u>No</u> premiums are payable for extra patients seen outside regular hours in the physician’s office or residence.			
Home Not applicable to Family Medicine – see applicable Preamble section			
<u>Special visit to the home premiums</u> – (1 st patient seen) – to be billed in addition to applicable home visit fee code.			
Monday to Friday between 8:00 a.m. and 6:00 p.m.			
60	- without sacrifice of office hours.....	NC	17.90
61	- with sacrifice of office hours	NC	35.80
62	Saturdays , Sundays or Statutory Holidays, or 6:00 p.m. to midnight.....	NC	35.80
63	Patient initiated non-elective (special) service rendered between midnight and 8:00 a.m. ...	NC	53.76
<u>Extra patient seen premiums</u>			
Monday to Friday between 8:00 a.m. and 6:00 p.m.			
66	- without sacrifice of office hours.....	NC	10.24
67	- with sacrifice of office hours	NC	15.32
68	Saturdays , Sundays or Statutory Holidays, or 6:00 p.m. to midnight.....	NC	15.32
69	Midnight to 8:00 a.m.	NC	23.49
Notes:			
1. Special visit premiums are <u>not</u> payable in addition to detention.			
2. NC = No charge			
Hospital In-Patient - see applicable Preamble Section			
<u>Premiums on in-patient services</u> – (1 st patient seen) – to be billed in addition to applicable in-patient fee code or alone if visit is not payable.			
Monday to Friday between 8:00 a.m. and 6:00 p.m.			
Physician in-hospital.....		NC	NC
70	- special visit, without sacrifice of office hours.....	20.18	20.18
71	- special visit, with sacrifice of office hours	40.25	40.25
72	Saturdays , Sundays or Statutory Holidays, or 6:00 p.m. to midnight	56.58	56.58
73	Non-elective (special) service rendered between midnight and 8:00 a.m.	84.89	84.89
<u>Extra patient seen premiums</u> – (in-patient) (when the physician has been specifically requested to see the patient)			
Monday to Friday between 8:00 a.m. and 6:00 p.m.			
76	- without sacrifice of office hours	11.48	11.48
77	- with sacrifice of office hours	17.25	17.25
78	Saturdays , Sundays, or Statutory Holidays, or 6:00 p.m. to midnight	27.58	27.58
79	Midnight to 8:00 a.m.	41.49	41.49
Notes:			
1. Special visit premiums are <u>not</u> payable in addition to detention.			
2. NC = No Charge			

CONSULTATIONS AND VISITS

SPECIAL VISIT PREMIUMS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP	Spec.
Hospital Out-Patient and Emergency – see applicable Preamble section			
<u>Premiums for physicians doing dedicated on-site emergency department coverage at approved Category 'A' facilities – to be billed in addition to visit fee code</u>			
Note: First patient seen during on-site coverage may be claimed as a special visit.			
First patient seen on shift			
80	- Monday to Friday , 8:00 a.m. to 6:00 p.m.	28.89	17.90
82	- Saturdays , Sundays or Statutory Holidays, or 6:00 p.m. to midnight	35.18	35.80
83	- midnight to 8:00 a.m.	42.01	53.76
Each additional patient seen on shift			
	- Monday to Friday , 8:00 am to midnight	NC	NC
88	- Saturdays , Sundays or Statutory Holidays, 8:00 a.m. to midnight	4.52	4.52
89	- midnight to 8:00 a.m.	7.41	7.41
 <u>Premiums on Emergency or OPD services – for physicians <u>not</u> doing dedicated on-site emergency department coverage at approved Category 'A' facilities – (1st patient seen) – to be billed in addition to applicable visit fee code.</u>			
Monday to Friday between 8:00 a.m. and 6:00 p.m.			
	- physician already in-hospital	NC	NC
90	- special visit, without sacrifice of office hours	31.17	20.18
91	- special visit, with sacrifice of office hours	39.61	40.25
92	Saturdays , Sundays or Statutory Holidays, or 6:00 p.m. to midnight	57.21	56.58
93	Non-elective (special) service rendered between midnight and 8:00 a.m.	72.58	84.89
<u>Extra patient seen premiums – (Emergency or OPD)</u>			
Monday to Friday between 8:00 a.m. and 6:00 p.m.			
96	- without sacrifice of office hours	11.48	11.48
97	- with sacrifice of office hours	17.25	17.25
98	Saturdays , Sundays or Statutory Holidays, or 6:00 p.m. to midnight	28.83	27.58
99	Midnight to 8:00 a.m.	41.49	41.49

Notes:

1. Special visit premiums are not applicable for scheduled OPD clinics.
2. Special visit premiums are not payable in addition to detention.
3. **NC = No Charge**

CONSULTATIONS AND VISITS

FAMILY MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Office		
101	Consultation	82.46
108	Sexual assault assessment	308.70
111	Pre-dental general assessment	65.97
112	General assessment	82.46
114	General reassessment	41.24
118	Routine post-operative care	32.98
121	Partial assessment	32.98
122	Visit for well-baby care	65.97
123	Partial assessment of a patient who is 65 to 74 years of age	41.24
124	Partial assessment of a patient who is 75 years of age or older	49.48
126	Partial assessment of a patient who received a WHSCC service during the same office visit	32.98
127	Chronic Disease Management of a patient under 75 years of age	49.48
128	Comprehensive Geriatric Assessment	363.00
129	Family Medicine Counselling, bill using fee code 121, 123, or 124, per ¼ hour add	10.00
	Psychotherapy:	
131	Individual, per ½ hour or major part thereof	65.97
132	Group (4 to 8 people) per member, per hour or major part thereof	24.74
136	Family therapy (2 or more family members), per ½ hour, per family	74.22
139	Add on fee for patients seen in scheduled after hours clinics, see General Preamble 7.1 for applicable codes	10.00
147	Driver medical examination of a patient who is 75 years of age or older, as required by Motor Registration for age (fee includes completion of any necessary documentation as per Section 3.3 of the MCP Medical Payment Schedule General Preamble)	100.00
150	Transition-Related Surgical Readiness Assessment	250.00
181	Detention per ¼ hour	35.71
Home		
210	Nursing home general assessment (except HCS designated facilities)	82.46
228	Comprehensive Geriatric Assessment	363.00
246	(a) "elective" and rendered any hour on any day (first patient seen), or (b) "non-elective" and rendered between 8:00 a.m. and 6:00 p.m. Monday through Friday (first patient seen)	89.05
248	"Non-elective" rendered between 8:00 a.m. and midnight on a Saturday , Sunday or Statutory Holiday (first patient seen)	115.44
249	"Non-elective" rendered between 6:00 p.m. and midnight (first patient seen)	115.44
250	"Non-elective" rendered between midnight and 8:00 a.m. (first patient seen)	148.43
251	Emergency visit with sacrifice of office hours – rendered as an immediate response to a call from the patient or the patient's attendant	115.44
252	Extra patient seen during any home visit	47.82
281	Detention per ¼ hour	35.71

CONSULTATIONS AND VISITS

FAMILY MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
HCS Designated Long-Term Care Facilities With Long Term Beds		
228	Comprehensive Geriatric Assessment	363.00
285	Nursing home <u>g</u> eneral assessment	82.46
286	(a) nursing home visit “elective” and rendered any hour on any day (first patient seen), or (b) nursing home visit “non-elective” and rendered between 8:00 a.m. and 6:00 p.m. Monday through Friday (first patient seen)	89.05
288	“Non-elective” nursing home visit rendered between 8:00 a.m. and midnight on a Saturday, Sunday or Statutory Holiday (first patient seen)	115.44
289	“Non-elective” nursing home visit rendered between 6:00 p.m. and midnight (first patient seen)	115.44
290	“Non-elective” nursing home visit rendered between midnight and 8:00 a.m. (first patient seen)	148.43
291	Emergency nursing home visit with sacrifice of office hours – (first patient seen) (this service must be in response to a medical emergency and must be rendered as an immediate response to a call from the patient or the patient’s attendant)	115.44
292	Extra patient seen during any nursing home visit	47.82
Hospital In-Patient		
301	Consultation	82.46
311	<u>P</u> re-dental general assessment	65.97
312	<u>G</u> eneral assessment	82.46
314	<u>G</u> eneral reassessment	41.24
328	Comprehensive Geriatric Assessment	363.00
	<u>P</u> sychotherapy	
331	Individual, (per ½ hour or major part thereof)	65.97
355	<u>I</u> n-patient surcharge for first 7 days – per diem	13.19
	<u>S</u> ubsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	41.23
357	6 th to 13 th week inclusive – per diem (visit type 3)	25.93
358	After 13 th week – per diem (visit type 4)	11.77
359	<u>I</u> n-patient surcharge, day of discharge	49.48
360	<u>C</u> oncurrent care, per visit	32.98
361	<u>N</u> ewborn baby care	65.97
	<u>S</u> upportive Care	
371	In 1 st 7 days – not exceeding 1 visit every 2 days – per visit	24.74
372	After 1 st 7 days – not exceeding 1 visit every 4 days – per visit	24.74
	<u>C</u> hronic and convalescent care:	
373	Maximum of 1 visit every 5 days	32.98
374	Attendance at high risk deliveries (per infant)	156.68
376	Medical Assistance in Dying (MAiD) related hospital in-patient during Contemplative Phase	80.51
381	Detention per ¼ hour	35.71

CONSULTATIONS AND VISITS

FAMILY MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Hospital Out-Patient and Emergency		
401	Consultation	82.46
408	Sexual assault assessment	308.70
411	<u>P</u> re-dental general assessment	65.97
412	<u>G</u> eneral assessment	82.46
414	<u>G</u> eneral reassessment	41.24
418	<u>R</u> outine post-operative care	32.98
421	<u>P</u> artial assessment	32.98
423	<u>P</u> artial assessment of a patient who is 65 to 74 years of age	41.24
424	<u>P</u> artial assessment of a patient who is 75 years of age or older	49.48
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit	32.98
428	<u>C</u>omprehensive Geriatric Assessment	363.00
	<u>P</u> sychotherapy:	
431	<u>I</u> ndividual, per ½ hour or major part thereof	65.97
432	<u>G</u> roup (4 to 8 people) per member, per hour or major part thereof	24.74
436	<u>F</u> amily therapy (2 or more family members) per ½ hour, per family	74.22
447	<u>D</u>river medical examination of a patient who is 75 years of age or older, as required by Motor Registration for age (fee includes completion of any necessary documentation as per Section 3.3 of the MCP Medical Payment Schedule General Preamble)	100.00
450	Transition-Related Surgical Readiness Assessment	250.00
481	<u>D</u> etention per ¼ hour	35.71
482	<u>E</u> scort of a critically ill patient per ¼ hour	71.43
 Physician on Duty at Designated 24 Hour On-Site Emergency Department (see Appendix A)		
401	Consultation	82.46
411	<u>P</u> re-dental general assessment	65.97
416	<u>C</u> omplex assessment	57.65
418	<u>R</u> outine post-operative care	32.98
421	<u>P</u> artial assessment	32.98
423	<u>P</u> artial assessment of a patient who is 65 to 74 years of age	41.24
424	<u>P</u> artial assessment of a patient who is 75 years of age or older	49.48
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit	32.98
	<u>P</u> sychotherapy:	
431	<u>I</u> ndividual, per ½ hour or major part thereof	65.97
432	<u>G</u> roup (4 to 8 people) per member, per hour or major part thereof	24.74
436	<u>F</u> amily therapy (2 or more family members) per ½ hour, per family	74.22
481	<u>D</u> etention per ¼ hour	35.71

CONSULTATIONS AND VISITS

FAMILY MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
-------------	--	-------------

FAMILY PRACTICE RENEWAL PROGRAM

The following codes apply only to eligible **family physicians** registered with the Fee Code Initiative of the Family Practice Renewal Program.

520	Shared Care (maximum 2 units per day)	30.00
-----	---	-------

Payable to fee-for-service **Family Physicians** for two-way collaborative conferencing, either by telephone or in person, between the **family physician** and at least one primary health care provider (excluding other **family physicians** and specialists). Conferencing cannot be delegated.

1. The conference may include, but does not require, the participation of the patient, and possibly family members, due to the severity of the patient's condition.
2. If the patient is present, the conference is payable at \$30.00 per 15 minutes (i.e. one unit), in addition to the normal visit fee. If the patient is not present, the conference is payable at \$30.00 per 15 minutes or greater part thereof (e.g. after 8 minutes of visit time). The conference is payable in addition to an office visit (same day) if required.
3. Conferences are payable to a maximum of 2 units per patient per day and to a maximum of 100 units per physician annually.
4. A care plan must be recorded in the patient chart and must include the following information:
 - Patient's name · Date(s) and time(s) of service · Diagnosis · Reason for need of Clinical Action Plan · Health care providers with whom the physician conferred & their role in provision of care · Clinical plan determined, including tests ordered and/or administered
5. This fee is not payable for situations where the purpose of the conference is to:
 - a. book an appointment; or
 - b. arrange for an expedited consultation or procedure; or
 - c. arrange for laboratory or diagnostic investigations; or
 - d. arrange a hospital or long term care bed for a patient; or
 - e. provide notification of services performed.
6. The conference must:
 - a. be pertinent to the treatment of the patient's current condition; and
 - b. involve two-way collaboration to determine an appropriate care plan for the patient.
7. If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.
8. The payment is made to the **family physician** regardless of who initiates the consultation.
9. This fee is not payable to physicians who are working under salary, service contract or sessional arrangements.

CONSULTATIONS AND VISITS

FAMILY MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Family Practice Renewal (Cont'd)		
521	Patient Care Telephone (maximum 4 units per day)	10.00
	<p>Payable to fee-for-service Family Physicians for two-way telephone communication between the physician (or other primary health care provider employed within the physician's office) and the patient (or the patient's medical representative).</p> <ol style="list-style-type: none"> 1. This code is not tied to a specific condition but requires a diagnostic code. 2. This code can be used at the discretion of the family physician for any patient for whom he/she is the designated primary care physician. 3. The telephone call is payable at \$10.00 per 5 minutes. (i.e. one unit) 4. Calls are payable for 4 units per patient per day and to a maximum of 225 units per physician annually. 5. Chart entry <u>must</u> record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed. 6. This fee is payable on the same calendar day as a visit or service fee by the same physician for the same patient. 7. This fee is <u>not</u> payable for simple prescription renewals, notifications of normal test results, or notification of office, referral or other appointments. 8. The payment is made to the family physician regardless of who initiates the call. 9. The fee is not payable to physicians who are working under salary, service contract or sessional arrangements. 	

CONSULTATIONS AND VISITS

ANAESTHESIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Fees for Anaesthesiology Consultations and Visit <u>must be coded as capacity "0"</u> on claims.		
Hospital In-Patient		
301	Consultation	114.49
302	Major medical consultation	114.49
308	Intra-operative consultation	114.49
311	<u>P</u> re-dental general assessment	55.16
312	<u>G</u> eneral assessment	54.24
313	<u>S</u> pecific assessment	47.50
315	<u>S</u> pecific reassessment	31.45
381	<u>D</u> etention per ¼ hour	34.87
Hospital Out-Patient and Emergency		
401	Consultation	114.49
409	<u>P</u> re-anaesthetic clinic assessment	92.20
411	<u>P</u> re-dental general assessment	55.16
412	<u>G</u> eneral assessment	54.24
413	<u>S</u> pecific assessment	47.50
415	<u>S</u> pecific reassessment	31.45
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	<u>D</u> etention per ¼ hour	34.87
482	<u>E</u> scort of a critically ill patient per ¼ hour	69.74
Hospital Pain Clinic		
These fee codes may <u>only</u> be billed by Anaesthesiologists working in an organized hospital pain clinic approved by the Regional Integrated Health Authority.		
400	Pain clinic consultation	140.60
419	Pain clinic reassessment	42.90
Pain Clinic Consultation – This service may <u>only</u> be claimed by Anaesthesiologists working in organized hospital pain clinics who are requested by other physicians to examine patients suffering from chronic pain and provide their opinion and recommendations in writing to the referring physician. The general definition and rules respecting consultations as described in General Preamble Section 6.1 apply to Pain Clinic Consultations.		
Pain Clinic Reassessment – Follow up visits to Anaesthesiologists working in organized hospital pain clinics are claimed using this code. This service consists of the necessary reassessment of the patient's response to treatment and an appropriate record.		

CONSULTATIONS AND VISITS

DERMATOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Office		
101	Consultation	95.20
113	<u>S</u> pecific assessment	49.81
115	<u>S</u> pecific reassessment	39.16
126	<u>P</u> artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	<u>D</u> etention per ¼ hour	34.87
Home		
201	Consultation	95.20
203	Consultation in HCS Designated Long Term Care Facility (see Appendix C)	147.30
213	<u>S</u> pecific assessment	49.81
215	<u>S</u> pecific reassessment	39.16
281	<u>D</u> etention per ¼ hour	34.87
Hospital In-Patient		
301	Consultation	95.20
313	<u>S</u> pecific assessment	49.81
315	<u>S</u> pecific reassessment	39.16
<u>S</u> ubsequent Visits:		
356	Up to 5 weeks – per diem (visit type 2)	34.56
357	6 th to 13 th week inclusive - per diem (visit type 3)	23.52
358	After 13 th week – per diem (visit type 4)	22.65
360	<u>C</u> oncurrent care, per visit	31.00
381	<u>D</u> etention per ¼ hour	34.87
Hospital Out-Patient and Emergency		
401	Consultation	95.20
413	<u>S</u> pecific assessment	49.81
415	<u>S</u> pecific reassessment	39.16
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	<u>D</u> etention per ¼ hour	34.87
482	<u>E</u> scort of a critically ill patient per ¼ hour	69.74

**CONSULTATIONS AND VISITS
EMERGENCY MEDICINE SPECIALIST**

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Hospital Out-Patient and Emergency		
401	Consultation	86.33
416	<u>C</u> omplex assessment	57.55
421	<u>P</u> artial assessment	23.87
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	<u>D</u> etention per ¼ hour	34.87
482	<u>E</u> scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

GENERAL, CARDIAC, VASCULAR OR THORACIC SURGERY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Office		
101	Consultation	95.94
103	Trauma consultation	160.00
113	<u>S</u> pecific assessment	56.12
115	<u>S</u> pecific reassessment	43.79
126	<u>P</u> artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	<u>D</u> etention per ¼ hour	34.87
Home		
201	Consultation	95.94
203	Trauma consultation	160.00
204	Major surgical consultation	160.00
213	<u>S</u> pecific assessment	56.12
215	<u>S</u> pecific reassessment	43.79
281	<u>D</u> etention per ¼ hour	34.87
Hospital In-Patient		
301	Consultation	95.94
303	Trauma consultation	160.00
304	Major surgical consultation	160.00
308	Intra-operative consultation	95.94
313	<u>S</u> pecific assessment	56.12
315	<u>S</u> pecific reassessment	43.79
<u>S</u> ubsequent Visits:		
356	Up to 5 weeks – per diem (visit type 2)	35.86
357	6 th to 13 th week inclusive – per diem (visit type 3)	24.41
358	After 13 th week – per diem (visit type 4)	23.51
360	<u>C</u> oncurrent care, per visit	35.86
381	<u>D</u> etention per ¼ hour	34.87
Hospital Out-Patient and Emergency		
401	Consultation	95.94
403	Trauma consultation	160.00
404	Major surgical consultation	160.00
413	<u>S</u> pecific assessment	56.12
415	<u>S</u> pecific reassessment	43.79
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	<u>D</u> etention per ¼ hour	34.87
482	<u>E</u> scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

INTERNAL MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Office		
101	Consultation	153.51
102	Major medical consultation	177.92
112	General assessment	79.85
113	Specific assessment	79.85
114	General reassessment	60.44
115	Specific reassessment	60.44
126	Partial assessment of a patient who received a WHSCC service during the same office visit	31.00
128	Comprehensive Geriatric Assessment	363.00
181	Detention per ¼ hour	34.87
190	Geriatric surcharge for patients 65 years of age and older	6.90
Home		
201	Consultation	153.51
202	Major medical consultation	177.92
212	General assessment	79.85
213	Specific assessment	79.85
214	General reassessment	60.44
215	Specific reassessment	60.44
228	Comprehensive Geriatric Assessment	363.00
281	Detention per ¼ hour	34.87
290	Geriatric surcharge for patients 65 years of age and older	6.90
Hospital In-Patient		
301	Consultation	153.51
302	Major medical consultation	177.92
308	Intra-operative consultation	153.51
311	Pre-dental general assessment	79.85
312	General assessment	79.85
313	Specific assessment	79.85
314	General reassessment	60.44
328	Comprehensive Geriatric Assessment	363.00
Subsequent visits:		
356	Up to 5 weeks – per diem (visit type 2)	41.23
357	6 th to 13 th week inclusive – per diem (visit type 3)	28.06
358	After 13 th week – per diem (visit type 4)	27.03
359	In-patient surcharge, day of discharge	80.00
360	Concurrent care, per visit	31.00
381	Detention per ¼ hour	34.87
390	Geriatric surcharge for patient 65 years of age and older	6.90

CONSULTATIONS AND VISITS

INTERNAL MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Hospital Out-Patient and Emergency		
401	Consultation	153.51
402	Major medical consultation	177.92
411	<u>P</u> re-dental general assessment	79.85
412	<u>G</u> eneral assessment	79.85
413	<u>S</u> pecific assessment	79.85
414	<u>G</u> eneral reassessment	60.44
415	<u>S</u> pecific reassessment	60.44
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit	31.00
428	<u>C</u>omprehensive Geriatric Assessment	363.00
481	<u>D</u> etention per ¼ hour	34.87
482	<u>E</u> scort of a critically ill patient per ¼ hour	69.74
490	<u>G</u> eriatric surcharge for patients 65 years of age and older	6.90

**CONSULTATIONS AND VISITS
NUCLEAR MEDICINE SPECIALIST**

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Rate
Hospital In-Patient	
301 Consultation*	111.14
Hospital Out-Patient and Emergency	
401 Consultation*	111.14

***A Nuclear Medicine Consultation is payable:**

1. When no isotope treatment is carried out. It is intended to recognize evaluation of the patient for whom treatment is found to be not indicated. To claim this fee the Nuclear Medicine Specialist is required to obtain from the patient a full history of the presenting problem, to perform a full physical examination (General Assessment) of the patient and review laboratory reports with respect to the requested treatment with non-sealed radioisotopes. When the decision is made to not proceed with the requested treatment or with any alternative treatment, a consultation report shall be sent to the physician who requested the isotope treatment, stating all of the above findings and giving the basis for the decision to not proceed.

OR

2. When scans done elsewhere are referred to a Nuclear Medicine Specialist for his/her written opinion. It is not payable for the reading of scans sent for reporting. As well, a consultation does not apply when the scans referred to above are used for comparison purposes with scans made in the consultant's facilities. Claims for consultation must be submitted IC and accompanied by a copy of the referring letter and the Nuclear Medicine Specialist's report.

**CONSULTATIONS AND VISITS
DEVELOPMENTAL NEUROLOGY**

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Office		
101	Consultation	145.00
102	Major neurological consultation	165.04
112	<u>G</u> eneral assessment	82.19
113	<u>S</u> pecific assessment	63.10
114	<u>G</u> eneral reassessment	64.46
115	<u>S</u> pecific reassessment	47.77
144	Scheduled interview with parent or teacher for investigation/management of a child's learning disability-per ½ hour or major part thereof	63.80
181	<u>D</u> etention per ¼ hour	34.87
Home		
201	Consultation	145.00
202	Major neurological consultation	165.04
212	<u>G</u> eneral assessment	82.19
213	<u>S</u> pecific assessment	63.10
214	<u>G</u> eneral reassessment	64.46
215	<u>S</u> pecific reassessment	47.77
281	<u>D</u> etention per ¼ hour	34.87
Hospital In-Patient		
301	Consultation	145.00
302	Major neurological consultation	165.04
312	<u>G</u> eneral assessment	82.19
313	<u>S</u> pecific assessment	63.10
314	<u>G</u> eneral reassessment	64.46
	<u>S</u> ubsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	41.23
357	6 th to 13 th week inclusive – per diem (visit type 3)	27.43
358	After 13 th week – per diem (visit type 4)	25.81
360	<u>C</u> oncurrent care, per visit	31.00
381	<u>D</u> etention per ¼ hour	34.87
Hospital Out-Patient and Emergency		
401	Consultation	145.00
402	Major neurological consultation	165.04
412	<u>G</u> eneral assessment	82.19
413	<u>S</u> pecific assessment	63.10
414	<u>G</u> eneral reassessment	64.46
415	<u>S</u> pecific reassessment	47.77
481	<u>D</u> etention per ¼ hour	34.87
482	<u>E</u> scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

NEUROLOGY (Except Developmental Neurology)

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Office		
101	Consultation	145.00
102	Major neurological consultation	165.04
112	<u>G</u> eneral assessment	82.19
113	<u>S</u> pecific assessment	63.10
114	<u>G</u> eneral reassessment	64.46
115	<u>S</u> pecific reassessment	47.77
126	<u>P</u> artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	<u>D</u> etention per ¼ hour	34.87
Home		
201	Consultation	145.00
202	Major neurological consultation	165.04
212	<u>G</u> eneral assessment	82.19
213	<u>S</u> pecific assessment	63.10
214	<u>G</u> eneral reassessment	64.46
215	<u>S</u> pecific reassessment	47.77
281	<u>D</u> etention per ¼ hour	34.87
Hospital In-Patient		
301	Consultation	145.00
302	Major neurological consultation	165.04
308	Intraoperative consultation	145.00
312	<u>G</u> eneral assessment	82.19
313	<u>S</u> pecific assessment	63.10
314	<u>G</u> eneral reassessment	64.46
	<u>S</u> ubsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	41.23
357	6 th to 13 th week inclusive – per diem (visit type 3)	27.43
358	After 13 th week – per diem (visit type 4)	25.81
360	<u>C</u> oncurrent care, per visit	31.00
381	<u>D</u> etention per ¼ hour	34.87
Hospital Out-Patient and Emergency		
401	Consultation	145.00
402	Major neurological consultation	165.04
412	<u>G</u> eneral assessment	82.19
413	<u>S</u> pecific assessment	63.10
414	<u>G</u> eneral reassessment	64.46
415	<u>S</u> pecific reassessment	47.77
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	<u>D</u> etention per ¼ hour	34.87
482	<u>E</u> scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

NEUROSURGERY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Office		
101	Consultation	122.97
103	Trauma consultation	145.14
104	Major surgical consultation	145.14
112	General assessment	63.85
113	Specific assessment	63.85
114	General reassessment	51.76
115	Specific reassessment	51.76
126	Partial assessment of a patient who received a WHSCC service during the same office visit	31.08
181	Detention per ¼ hour	34.87
Home		
201	Consultation	122.97
203	Trauma consultation	145.14
204	Major surgical consultation	145.14
212	General assessment	63.85
213	Specific assessment	63.85
214	General reassessment	51.76
215	Specific reassessment	51.76
281	Detention per ¼ hour	34.87
Hospital In-Patient		
301	Consultation	122.97
303	Trauma consultation	145.14
304	Major surgical consultation	145.14
308	Intraoperative consultation	122.97
312	General assessment	63.85
313	Specific assessment	63.85
314	General reassessment	51.76
315	Specific reassessment	51.76
Subsequent visits:		
356	Up to 5 weeks – per diem (visit type 2)	38.19
357	6 th to 13 th week inclusive – per diem (visit type 3)	25.99
358	After 13 th week – per diem (visit type 4)	25.03
359	In-patient surcharge, day of discharge	48.31
360	Concurrent care, per visit	31.00
381	Detention per ¼ hour	34.87
Hospital Out-Patient and Emergency		
401	Consultation	122.97
403	Trauma consultation	145.14
404	Major surgical consultation	145.14
412	General assessment	63.85
413	Specific assessment	63.85
414	General reassessment	51.76
415	Specific reassessment	51.76
426	Partial assessment of a patient who received a WHSCC service during the same visit	31.08
481	Detention per ¼ hour	34.87
482	Escort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

OBSTETRICS AND GYNECOLOGY AND GYNECOLOGICAL ONCOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Office		
101	Consultation	92.17
104	Major surgical consultation	148.10
113	S pecific assessment	54.13
115	S pecific reassessment	39.88
150	Transition-Related Surgical Readiness Assessment	250.00
181	D etention per ¼ hour	34.87
Home		
201	Consultation	92.17
204	Major surgical consultation	148.10
213	S pecific assessment	54.13
215	S pecific reassessment	39.88
281	D etention per ¼ hour	34.87
Hospital In-Patient		
301	Consultation	92.17
304	Major surgical consultation	148.10
307	H igh risk prenatal consultation by MFM specialist, 40 minutes or more	148.10
308	Intra-operative consultation	92.17
313	S pecific assessment	54.13
315	S pecific reassessment	39.88
317	H igh risk prenatal assessment by MFM specialist, 20 minutes or more	78.69
	Subsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	38.14
357	6 th to 13 th week inclusive – per diem (visit type 3)	25.01
358	After 13 th week – per diem (visit type 4)	24.09
360	C oncurrent care, per visit	31.00
361	N ewborn baby care in hospital (up to 10 days)	63.50
381	D etention per ¼ hour	34.87
Hospital Out-Patient and Emergency		
401	Consultation	92.17
404	Major surgical consultation	148.10
407	H igh risk prenatal consultation by MFM specialist, 40 minutes or more	148.10
413	S pecific assessment	54.13
415	S pecific reassessment	39.88
417	H igh risk prenatal assessment by MFM specialist, 20 minutes or more	78.69
450	Transition-Related Surgical Readiness Assessment	250.00
481	D etention per ¼ hour	34.87
482	E scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

OPHTHALMOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Office		
101	Consultation*	91.58
106	Special ophthalmology consultation	151.16
113	S pecific assessment	57.32
115	S pecific reassessment	37.50
126	P artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	D etention per ¼ hour	34.87
Home		
201	Consultation*	91.58
213	S pecific assessment	57.32
215	S pecific reassessment	37.50
281	D etention per ¼ hour	34.87
Hospital In-Patient		
301	Consultation*	91.58
306	Special ophthalmology consultation	151.16
308	Intraoperative consultation	91.58
313	S pecific assessment	57.32
315	S pecific reassessment	37.50
Subsequent visits:		
356	Up to 5 weeks – per diem (visit type 2)	31.00
357	6 th to 13 th week inclusive – per diem (visit type 3)	21.10
358	After 13 th week – per diem (visit type 4)	20.32
360	C oncurrent care, per visit	31.00
381	D etention per ¼ hour	34.87

CONSULTATIONS AND VISITS

OPHTHALMOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Hospital Out-Patient and Emergency		
401	Consultation*	91.58
406	Special ophthalmology consultation	151.16
413	<u>S</u> pecific assessment	57.32
415	<u>S</u> pecific reassessment	37.50
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	<u>D</u> etention per ¼ hour	34.87
482	<u>E</u> scort of a critically ill patient per ¼ hour	69.74

In addition to a physician, referrals will be accepted from an optometrist with the proviso that a copy of the consultation report be sent to the patient's **Family Physician.*

CONSULTATIONS AND VISITS

ORTHOPAEDIC SURGERY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Office		
101	Consultation	95.00
103	Trauma consultation	143.09
104	Major surgical consultation	143.09
105	Back consultation for suspected spinal disorder	119.52
113	S pecific assessment	51.74
115	S pecific reassessment	36.41
126	P artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	D etention per ¼ hour	34.87
Home		
201	Consultation	95.00
203	Trauma consultation	143.09
204	Major surgical consultation	143.09
205	Back consultation for suspected spinal disorder	119.52
213	S pecific assessment	51.74
215	S pecific reassessment	36.41
281	D etention per ¼ hour	34.87
Hospital In-Patient		
301	Consultation	95.00
303	Trauma consultation	143.09
304	Major surgical consultation	143.09
305	Back consultation for suspected spinal disorder	119.52
308	Intraoperative consultation	95.00
313	S pecific assessment	51.74
315	S pecific reassessment	36.41
	Subsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	33.91
357	6 th to 13 th week inclusive – per diem (visit type 3)	23.08
358	After 13 th week – per diem (visit type 4)	22.23
360	C oncurrent care, per visit	31.00
381	D etention per ¼ hour	34.87
Hospital Out-Patient and Emergency		
401	Consultation	95.00
403	Trauma consultation	143.09
404	Major surgical consultation	143.09
405	Back consultation for suspected spinal disorder	119.52
413	S pecific assessment	51.74
415	S pecific reassessment	36.41
426	P artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	D etention per ¼ hour	34.87
482	E scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

OTOLARYNGOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Office		
101	Consultation	83.38
113	S pecific assessment	48.49
115	S pecific reassessment	33.49
126	P artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	D etention per ¼ hour	34.87
Home		
201	Consultation	83.38
213	S pecific assessment	48.49
215	S pecific reassessment	33.49
281	D etention per ¼ hour	34.87
Hospital In-Patient		
301	Consultation	83.38
308	Intraoperative consultation	83.38
313	S pecific assessment	48.49
315	S pecific reassessment	33.49
	S ubsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	32.47
357	6 th to 13 th week inclusive – per diem (visit type 3)	22.10
358	After 13 th week – per diem (visit type 4)	21.28
360	C oncurrent care, per visit	31.00
381	D etention per ¼ hour	34.87
Hospital Out-Patient and Emergency		
401	Consultation	83.38
413	S pecific assessment	48.49
415	S pecific reassessment	33.49
426	P artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	D etention per ¼ hour	34.87
482	E scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

PAEDIATRICS (Except Developmental Paediatrics)

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Office		
101	Consultation	195.84
102	Major medical consultation	179.18
107	Prenatal consultation	195.84
112	G eneral assessment	98.72
113	S pecific assessment	98.72
114	G eneral reassessment	93.05
115	S pecific reassessment	93.05
122	Visit for w ell-baby care	32.49
141	I nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	64.31
181	D etention per ¼ hour	35.98
Home		
201	Consultation	195.84
202	Major medical consultation	179.18
207	Prenatal consultation	195.84
212	G eneral assessment	98.72
213	S pecific assessment	98.72
214	G eneral reassessment	93.05
241	I nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	64.31
252	Extra patient seen	15.41
281	D etention per ¼ hour	35.98
Hospital In-Patient		
301	Consultation	195.84
302	Major medical consultation	179.18
307	Prenatal consultation	195.84
308	Intra-operative consultation	195.84
311	P re-dental general assessment	98.72
312	G eneral assessment	98.72
313	S pecific assessment	98.72
314	G eneral reassessment	93.05
341	I nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	64.31
	S ubsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	35.34
357	6 th to 13 th week inclusive – per diem (visit type 3)	22.38
358	After 13 th week – per diem (visit type 4)	21.55
360	C oncurrent care, per visit	31.00
361	N ewborn baby care in hospital	64.98
374	A ttendance at high risk delivery (per infant)	149.58
381	D etention per ¼ hour	35.98

CONSULTATIONS AND VISITS

PAEDIATRICS (Except Developmental Paediatrics)

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Hospital Out-Patient and Emergency		
401	Consultation	195.84
402	Major medical consultation	179.18
407	Prenatal consultation	195.84
411	P re-dental general assessment	98.72
412	G eneral assessment	98.72
413	S pecific assessment	98.72
414	G eneral reassessment	93.05
415	S pecific reassessment	93.05
421	P artial assessment	33.52
441	I nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	64.31
481	D etention per ¼ hour	35.98
482	E scort of a critically ill patient per ¼ hour	71.96
Physician on Duty at Designated 24 Hour On-Site Emergency Department (see Appendix A)		
401	Consultation	195.84
402	Major medical consultation	179.18
407	Prenatal consultation	195.84
411	P re-dental general assessment	98.72
413	S pecific assessment	98.72
415	S pecific reassessment	93.05
416	C omplex assessment	56.29
421	P artial assessment	33.52
441	I nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	64.31
481	D etention per ¼ hour	35.98
482	E scort of a critically ill patient per ¼ hour	71.96

CONSULTATIONS AND VISITS
DEVELOPMENTAL PAEDIATRICS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Office		
101	Consultation	195.84
102	Major medical consultation	179.18
107	Prenatal consultation	195.84
112	G eneral assessment	98.72
113	S pecific assessment	98.72
114	G eneral reassessment	93.05
115	S pecific reassessment	93.05
122	Visit for w ell-baby care	32.49
141	I nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	64.31
144	Scheduled i nterview with parent, guardian or other professional for investigation/management of a patient's physical, cognitive or emotional disability – per ½ hour or major part thereof	100.46
181	D etention per ¼ hour	35.98
Home		
201	Consultation	195.84
202	Major medical consultation	179.18
207	Prenatal consultation	195.84
212	G eneral assessment	98.72
213	S pecific assessment	98.72
214	G eneral reassessment	93.05
241	I nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	64.31
252	Extra patient seen	15.41
281	D etention per ¼ hour	35.98
Hospital In-Patient		
301	Consultation	195.84
302	Major medical consultation	179.18
307	Prenatal consultation	195.84
311	P re-dental general assessment	98.72
312	G eneral assessment	98.72
313	S pecific assessment	98.72
314	G eneral reassessment	93.05
341	I nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	64.31
	S ubsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	35.34
357	6 th to 13 th week inclusive – per diem (visit type 3)	22.38
358	After 13 th week – per diem (visit type 4)	21.55
360	C oncurrent care, per visit	31.00
361	N ewborn baby care in hospital	64.98
374	A ttendance at high risk delivery (per infant)	149.58
381	D etention per ¼ hour	35.98

CONSULTATIONS AND VISITS
DEVELOPMENTAL PAEDIATRICS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Hospital Out-Patient and Emergency		
401	Consultation	195.84
402	Major medical consultation	179.18
407	Prenatal consultation	195.84
411	<u>P</u> re-dental general assessment	98.72
412	<u>G</u> eneral assessment	98.72
413	<u>S</u> pecific assessment	98.72
414	<u>G</u> eneral reassessment	93.05
415	<u>S</u> pecific reassessment	93.05
421	<u>P</u> artial assessment	33.52
441	<u>I</u> nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	64.31
481	<u>D</u> etention per ¼ hour	35.98
482	<u>E</u> scort of a critically ill patient per ¼ hour	71.96

CONSULTATIONS AND VISITS

PHYSICAL MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Office		
101	Consultation	94.42
113	<u>S</u> pecific assessment	47.39
115	<u>S</u> pecific reassessment	36.93
126	<u>P</u> artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	<u>D</u> etention per ¼ hour	34.87
Home		
201	Consultation	94.42
213	<u>S</u> pecific assessment	47.39
215	<u>S</u> pecific reassessment	36.93
281	<u>D</u> etention per ¼ hour	34.87
Hospital In-Patient		
301	Consultation	94.42
313	<u>S</u> pecific assessment	47.39
315	<u>S</u> pecific reassessment	36.93
342	<u>I</u> nterviewing and counselling of patients and/or relatives, per ½ hour or major part thereof	39.53
	<u>S</u> ubsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	31.00
357	6 th to 13 th week inclusive – per diem (visit type 3)	20.35
358	After 13 th week – per diem (visit type 4)	19.60
360	<u>C</u> oncurrent care, per visit	31.00
375	<u>P</u> hysiatric management	2.71
381	<u>D</u> etention per ¼ hour	34.87
Hospital Out-Patient and Emergency		
401	Consultation	94.42
413	<u>S</u> pecific assessment	47.39
415	<u>S</u> pecific reassessment	36.93
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit	31.00
442	<u>I</u> nterviewing and counselling or patients and/or relatives, per ½ hour or major part thereof	39.53
475	<u>P</u> hysiatric management	2.71
481	<u>D</u> etention per ¼ hour	34.87
482	<u>E</u> scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

PLASTIC SURGERY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Office		
101	Consultation	84.93
104	Major surgical consultation	169.85
113	<u>S</u> pecific assessment	43.35
115	<u>S</u> pecific reassessment	34.89
126	<u>P</u> artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	<u>D</u> etention per ¼ hour	34.87
Home		
201	Consultation	84.93
204	Major surgical consultation	169.85
213	<u>S</u> pecific assessment	43.35
215	<u>S</u> pecific reassessment	34.89
281	<u>D</u> etention per ¼ hour	34.87
Hospital In-Patient		
301	Consultation	84.93
304	Major surgical consultation	169.85
308	Intraoperative consultation	84.93
313	<u>S</u> pecific assessment	43.35
315	<u>S</u> pecific reassessment	34.89
	<u>S</u> ubsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	35.39
357	6 th to 13 th week inclusive – per diem (visit type 3)	24.09
358	After 13 th week – per diem (visit type 4)	23.20
360	<u>C</u> oncurrent care, per visit	31.00
381	<u>D</u> etention per ¼ hour	34.87
Hospital Out-Patient and Emergency		
401	Consultation	84.93
404	Major surgical consultation	169.85
413	<u>S</u> pecific assessment	43.35
415	<u>S</u> pecific reassessment	34.89
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	<u>D</u> etention per ¼ hour	34.87
482	<u>E</u> scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

PSYCHIATRY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Office		
101	Consultation	250.00
113	<u>S</u> pecific assessment	79.85
115	<u>S</u> pecific reassessment	61.25
126	<u>P</u> artial assessment of a patient who received a WHSCC service during the same office visit	31.00
128	<u>S</u>pecific neurocognitive assessment	62.75
130	<u>P</u> sychiatric care, per ½ hour or major part thereof	90.35
	<u>P</u> sychotherapy	
131	Individual, per ½ hour or major part thereof	90.35
133	Group of 4 people, per member, per hour or major part thereof	34.37
134	Group of 5 people, per member, per hour or major part thereof	27.50
135	Group of 6-12 people, per member, per hour or major part thereof	22.91
136	Family therapy, 2 or more family members, per ½ hour, per family	91.10
137	<u>I</u> nitial interview with parent or guardian (when seen separately) on behalf of emotionally disturbed child	62.75
138	<u>C</u> ase consultation with a child welfare or correctional worker, teacher, community health nurse, or other allied professional, in person, on behalf of a child or adolescent – per ½ hour or major part thereof	91.00
139	<u>I</u> nterview with child or adolescent – per ½ hour or major part thereof	53.36
140	<u>D</u> iagnostic or therapeutic interview with a parent, guardian, foster parent, or group home parent of a child or adolescent – per ½ hour or major part thereof	62.75
150	<u>T</u>ransition-Related Surgical Readiness Assessment	250.00
160	<u>T</u> ransfer of care surcharge – after a minimum of 6 follow up visits	99.78
181	<u>D</u> etention per ¼ hour	34.87
Home		
201	Consultation	250.00
213	<u>S</u> pecific assessment	79.85
215	<u>S</u> pecific reassessment	61.25
216	<u>S</u> pecific assessment at the lock-up at the custodian's request	116.26
228	<u>S</u>pecific neurocognitive assessment	62.75
230	<u>P</u> sychiatric care, per ½ hour or major part thereof	90.35
	<u>P</u> sychotherapy	
231	Individual, per ½ hour or major part thereof	90.35
233	Group of 4 people, per member, per hour or major part thereof	34.37
234	Group of 5 people, per member, per hour or major part thereof	27.50
235	Group of 6-12 people, per member, per hour or major part thereof	22.91
238	<u>C</u> ase consultation with a child welfare or correctional worker, teacher, community health or nurse, or other allied professional, in person, on behalf of a child or adolescent – per ½ hour or major part thereof	91.00
239	<u>I</u> nterview with child or adolescent – per ½ hour or major part thereof	53.36
240	<u>D</u> iagnostic or therapeutic interview with a parent, guardian, foster parent, or group home parent of a child or adolescent – per ½ hour or major part thereof	62.75
252	<u>E</u> xtra patient seen	12.44
281	<u>D</u> etention per ¼ hour	34.87

CONSULTATIONS AND VISITS

PSYCHIATRY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Hospital In-Patient		
301	Consultation	250.00
313	S pecific assessment	79.85
315	S pecific reassessment	61.25
328	S pecific neurocognitive assessment	62.75
330	P sychiatric care, per ½ hour or major part thereof	90.35
Psychotherapy:		
331	Individual, per ½ hour or major part thereof	90.35
333	Group of 4 people, per member, per hour or major part thereof	34.37
334	Group of 5 people, per member, per hour or major part thereof	27.50
335	Group of 6-12 people, per member, per hour or major part thereof	22.91
336	Family, where at least one member is an in-patient, 2 or more family members, per ½ hour, per family	91.10
338	C ase consultation with a child welfare or correctional worker, teacher, community health or nurse, or other allied professional, in person, on behalf of a child or adolescent – per ½ hour major part thereof	91.00
339	I nterview with child or adolescent – per ½ hour or major part thereof	53.36
340	Diagnostic or therapeutic interview with a parent, guardian, foster parent, or group home parent of a child or adolescent – per ½ hour or major part thereof	62.75
In-patient surcharge		
352	- day 1 to 14, per day	29.35
353	- days 15 to 28, per day	17.61
Subsequent visits:		
356	Up to 5 weeks – per diem (visit type 2)	36.39
357	6 th to 13 th week inclusive – per diem (visit type 3).....	25.90
358	After 13 th week – per diem (visit type 4)	24.93
359	In-patient surcharge, day of discharge	100.00
360	C oncurrent care, per visit	36.39
381	D etention per ¼ hour	34.87

CONSULTATIONS AND VISITS

PSYCHIATRY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Hospital Out-Patient and Emergency		
401	Out Patient Clinic Consultation	250.00
402	Emergency Department Consultation	325.00
413	S pecific assessment	79.85
415	S pecific reassessment	61.25
426	P artial assessment of a patient who received a WHSCC service during the same visit	31.00
428	P specific neurocognitive assessment	62.75
430	P sychiatric care, per ½ hour or major part thereof	90.35
	P sychotherapy:	
431	Individual, per ½ hour or major part thereof	90.35
433	Group of 4 people, per member, per hour or major part thereof	34.37
434	Group of 5 people, per member, per hour or major part thereof	27.50
435	Group of 6-12 people, per member, per hour or major part thereof	22.91
436	Family therapy, 2 or more family members, per ½ hour, per family	91.10
438	C ase consultation with a child welfare or correctional worker, teacher, community health or nurse, or other allied professional, in person, on behalf of a child or adolescent – per ½ hour major part thereof	91.00
439	I nterview with child or adolescent – per ½ hour or major part thereof	53.36
440	Diagnostic or therapeutic interview with a parent, guardian, foster parent, or group home parent of a child or adolescent – per ½ hour or major part thereof	62.75
450	T ransition-Related Surgical Readiness Assessment	250.00
476	P sychiatry day care – per visit, per patient	22.71
481	D etention per ¼ hour	34.87
482	E scort of a critically ill patient, per ¼ hour	69.74

* In addition to a physician, referrals for patients aged 2 to 17 years will be accepted from a child welfare or correctional worker, guidance counselor or teacher with the proviso that a copy of the consultation report be sent to the patient's **family physician**.

CONSULTATIONS AND VISITS

UROLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Office		
101	Consultation*	84.86
104	Major surgical consultation	138.40
113	<u>S</u> pecific assessment	54.51
115	<u>S</u> pecific reassessment	38.67
126	<u>P</u> artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	<u>D</u> etention per ¼ hour	34.87
Home		
201	Consultation*	84.86
204	Major surgical consultation	138.40
213	<u>S</u> pecific assessment	54.51
215	<u>S</u> pecific reassessment	38.67
281	<u>D</u> etention per ¼ hour	34.87
Hospital In-Patient		
301	Consultation*	84.86
304	Major surgical consultation	138.40
308	Intraoperative consultation	84.86
313	<u>S</u> pecific assessment	54.51
315	<u>S</u> pecific reassessment	38.67
	<u>S</u> ubsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	34.91
357	6 th to 13 th weeks inclusive – per diem (visit type 3)	23.76
358	After 13 th week – per diem (visit type 4)	22.88
360	<u>C</u> oncurrent care, per visit	31.00
381	<u>D</u> etention per ¼ hour	34.87
Hospital Out-Patient and Emergency		
401	Consultation*	84.86
404	Major surgical consultation	138.40
413	<u>S</u> pecific assessment	54.51
415	<u>S</u> pecific reassessment	38.67
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	<u>D</u> etention per ¼ hour	34.87
482	<u>E</u> scort of a critically ill patient per ¼ hour	69.74

* Includes, when necessary, urethral calibration, catheterization and prostatic fluid examinations but not to include endoscopic examination.

CONSULTATIONS AND VISITS

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Hospital In-Patient		
301	Diagnostic Radiology Consultation	127.17
302	Interventional Radiology Consultation	127.17
Hospital Out-Patient and Emergency		
401	Diagnostic Radiology Consultation	127.17
402	Interventional Radiology Consultation	127.17

1. A Diagnostic Radiology Consultation applies when insured imaging studies made elsewhere are referred to a Radiologist for his/her written opinion. It is not payable for the reading of insured imaging studies sent for reporting. As well, a consultation does not apply when the insured imaging studies referred to above are used for comparison purposes with images made in the consultant's facilities. Claims for consultation must be submitted IC and accompanied by a copy of the referring letter and the Radiologist's report.

2. **An Interventional Radiology (IR) Consultation applies when an Interventional Radiologist is requested by a physician or nurse practitioner to assess a patient referred for an interventional radiological procedure which requires extensive discussion with the patient. Examples of such procedures include, but are not limited to, the following: endovascular obliteration of cerebral aneurysms and vascular malformations including pelvic congestion syndrome, embolization of uterine fibroids, percutaneous image guided radiofrequency ablation of solid tumours, trans-arterial chemo embolization. The IR consultation is not payable for the following procedures: simple biopsies or aspirations; the routine task of obtaining consent; or for any procedures where direct interaction with the patient is not warranted. The Interventional Radiologist must give their opinion in writing to the referring physician or nurse practitioner. This opinion must include documentation of the pertinent patient history and physical examination, and a discussion of the risks and limitations of the procedure. The consultation is payable whether or not the Interventional Radiologist actually performs the procedure.**

Billing of an IR Consultation is restricted to those physicians certified by the Royal College of Physicians and Surgeons of Canada in Interventional Radiology. Other Interventional Radiologists may be considered upon request to the Assistant Medical Director.

VIRTUAL HEALTH TELEMEDICINE PREAMBLE

1. GENERAL POLICY

- 1.1 "Telemedicine service" is a medical service provided to an MCP beneficiary presenting at an approved telemedicine site in Newfoundland and Labrador, through a direct interactive video link with a receiving physician at an approved telemedicine site in Newfoundland and Labrador (see Appendix H for the list of approved sites). The patient must be present at the same time as the physician.
- 1.2 Only physicians eligible to bill fee-for-service are allowed to bill MCP for telemedicine payments.
- 1.3 The codes listed in this Telemedicine Schedule must be used for telemedicine services without substitution. Claims must be coded with the hospital number for the site where the physician is located.
- 1.4 Teleradiology services should be billed using codes listed in the Radiology section of the MCP Medical Payment Schedule. They cannot be billed using the codes listed in the Telemedicine schedule.

2. TERMS AND CONDITIONS FOR TELEMEDICINE CODES

- 2.1 Telemedicine services must meet all the requirements, including documentation requirements, for comparable consultation and assessment codes listed in the MCP Medical Payment Schedule except that the requirement for physical examination does not apply:
 - (a) Telemedicine consultations must be documented with a written request from the referring physician, a record of the history, and a letter back to the referring physician.
 - (b) Telemedicine services for a non-referred patient should be claimed using a reassessment code.
 - (c) The record of a telemedicine reassessment must include: the reason for the encounter; findings through history; working diagnosis and/or plan of investigation or treatment.
 - 2.2 Where a receiving physician, after having provided a telemedicine service to a patient, decides he/she must examine the patient in person, the physician may claim a MCP major examination fee for the in-person examination, notwithstanding that the in-person examination has been provided within ninety (90) days of the telemedicine service.
 - 2.3 Where telemedicine services are interrupted for because of a loss of transmission capacity beyond the control of the physician, and are not able to be resumed within the time allocated, and are therefore not able to be completed:
 - (a) the physician shall be entitled to claim for the telemedicine services which he/she began to provide prior to the interruption, to the same effect as if the provision of the services had been completed. Remarks code 50 – Telemedicine service interrupted by loss of transmission capacity should be entered on claims for such services;
 - (b) where a telemedicine consultation service is provided to the patient for the same condition by the same physician subsequent to a service that was interrupted by a loss of transmission capacity, the physician shall be entitled to claim for the second telemedicine consultation service, notwithstanding that the second service has been provided within ninety (90) days of the initial interrupted telemedicine consultation service. The claim for the initial service must be coded with remarks code 50.
-

**VIRTUAL HEALTH
TELEMEDICINE PREAMBLE**

- 2.4 Where there is no loss of transmission capacity and telemedicine services did not take place because the time allocated expired or the physician temporarily discontinued telemedicine work for another reason, no claims can be submitted to MCP for the services that did not take place.

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
FAMILY MEDICINE		
502	Telemedicine partial assessment	32.20
503	Telemedicine partial assessment of a patient who is 65 to 74 years of age	40.26
504	Telemedicine partial assessment of a patient who is 75 years of age or older	48.31
Psychotherapy:		
511	Individual, per ½ hour or major part thereof	64.41
512	Group (4 to 8 people) per member, per hour or major part thereof	24.15
513	Family therapy (2 or more family members), per ½ hour, per family	72.46
Supportive Care:		
531	In 1 st 7 days – not exceeding 1 encounter every 2 days – per encounter	24.15
532	After 1 st 7 days – not exceeding 1 encounter every 4 days – per encounter	24.15
539	Add on fee for patient encounter between 6:00 p.m. and midnight on weekdays, on weekends, or on MCP Statutory Holidays	10.00

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Rate
DERMATOLOGY	
501	Consultation 91.52
502	Reassessment 41.70

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Rate
GENERAL SURGERY	
501	Consultation 91.78
502	Reassessment 46.13

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Rate
INTERNAL MEDICINE	
501	Consultation 150.82
502	Reassessment 66.91

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Rate
NUCLEAR MEDICINE	
501	Consultation 111.14

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
DEVELOPMENTAL NEUROLOGY		
501	Consultation	145.00
502	Reassessment	46.16
515	Scheduled interview with parent or teacher for investigation/management of a child's learning disability – per ½ hour or major part thereof	63.80

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Rate
NEUROLOGY	
501	145.00
502	46.16

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Rate
NEUROSURGERY	
501	Consultation 121.10
502	Reassessment 50.90

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Rate
OBSTETRICS AND GYNECOLOGY	
501	87.50
502	41.00

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Rate
OPHTHALMOLOGY	
501	Consultation 85.97
502	Reassessment 44.10

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Rate
ORTHOPAEDICS	
501	90.74
502	40.11

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Rate
OTOLARYNGOLOGY	
501	Consultation 79.34
502	Reassessment 36.83

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
PAEDIATRICS		
501	Consultation	174.04
502	Reassessment	89.80
513	Interview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	62.33

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
DEVELOPMENTAL PAEDIATRICS		
501	Consultation	174.04
502	Reassessment	89.80
513	Interview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	62.33
514	Scheduled interview with parent, guardian or other professional for investigation/management of a patients physical, cognitive or emotional disability - per ½ hour or major part thereof	100.46

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Rate
PHYSICAL MEDICINE	
501	Consultation 94.42
502	Reassessment 42.16

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Rate
PLASTIC SURGERY	
501	Consultation 79.22
502	Reassessment 36.14

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
PSYCHIATRY		
501	Consultation	250.00
502	Reassessment	67.45
504	Psychiatric care, per ½ hour or major part thereof	86.57
	Psychotherapy:	
505	Individual, per ½ hour or major part thereof	86.57
506	Group of 4 people, per member, per hour or major part thereof	34.37
507	Group of 5 people, per member, per hour or major part thereof	27.50
508	Group of 6-12 people, per member, per hour or major part thereof	22.91
509	Family therapy, 2 or more family members, per ½ hour, per family	91.10
510	Case consultation with a child welfare or correctional worker, teacher, community health or nurse, or other allied professional, in person, on behalf of a child or adolescent – per ½ hour or major part thereof	62.75
511	Interview with child or adolescent – per ½ hour or major part thereof	53.36
512	Diagnostic or therapeutic interview with a parent, guardian, foster parent, or group home parent of a child or adolescent – per ½ hour or major part thereof	62.75

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Rate
UROLOGY	
501	Consultation 84.86
502	Reassessment 40.00

Appendix H

VIRTUAL HEALTH

APPROVED TELEMEDICINE SITES

Facility Number	Telemedicine Site Name
Eastern Regional Health Authority	
022	U.S. Memorial Health Centre, St. Lawrence
112	Major's Path Community Health Clinic, St. John's
124	Dr. H. Bliss Murphy Cancer Centre, St. John's
230	Carbonear General Hospital, Carbonear
248	Dr. G. B. Cross Memorial Hospital, Clarenville
256	Health Sciences Centre, (General Hospital) St. John's
264	St. Clare's Mercy Hospital, St. John's
281	Janeway Children's Health and Rehabilitation Centre, St. John's
302	Burin Peninsula Health Care Centre, Burin
337	Dr. A.A. Wilkinson Memorial Health Centre, Old Perlican
345	Bonavista Peninsula Health Centre, Bonavista
353	Dr. Walter Templeman Health Care Centre, Bell Island
361	Mental Health and Addictions Centre, St. John's
370	Dr. Leonard A. Miller Centre, St. John's
371	Dr. Leonard A. Miller Centre, Family Practice Clinic, St. John's
375	Eastern Health Opioid Treatment Centre
380	Eastern Health Recovery Centre
400	Newhook Community Health Centre, Whitbourne
418	Placentia Health Centre, Placentia
671	Clarenville Correctional Centre for Women, Clarenville
736	Newfoundland & Labrador Youth Centre, Whitbourne
800	Salvation Army Glenbrook Lodge, St. John's
802	St. Patrick's Mercy Home, St. John's
804	Saint Luke's Nursing Home, St. John's
806	Agnes Pratt Nursing Home, St. John's
810	Pleasant View Towers, St. John's
818	Bluecrest Nursing Home, Grand Bank
819	Dr. Albert A. O'Mahoney Memorial Manor, Clarenville
870	Grand Bank Health Centre, Grand Bank

Appendix H

VIRTUAL HEALTH

APPROVED TELEMEDICINE SITES

Facility Number	Telemedicine Site Name
Central Regional Health Authority	
051	Baie Verte Peninsula Health Centre, Baie Verte
205	James Paton Memorial Regional Health Centre, Gander
213	Central Newfoundland Regional Health Centre, Grand Falls-Windsor
221	Notre Dame Bay Memorial Health Centre, Twillingate
299	Brookfield Bonnews Health Care Centre, Brookfield
311	Connaigre Peninsula Health Centre, Harbour Breton
329	Fogo Island Health Centre, Fogo
426	Green Bay Community Health Centre, Springdale
434	A.M. Guy Memorial Health Centre, Buchans
451	Dr. Hugh Twomey Health Centre, Botwood
698	Bishop's Falls Correctional Centre, Bishop's Falls
824	North Haven Manor, Lewisporte
854	Glovertown Clinic, Glovertown
906	Bay d'Espoir Community Health Centre, St. Alban's
907	Conne River Health Clinic, Conne River
Western Regional Health Authority	
175	Western Memorial Regional Hospital, Corner Brook
183	Sir Thomas Roddick Hospital, Stephenville
191	Dr. Charles L. Legrow Health Centre, Port aux Basques
388	Calder Health Centre, Burgeo
396	Rufus Guinchard Health Centre, Port Saunders
442	Bonne Bay Health Centre, Norris Point
680	Stephenville Correctional Centre For Men, Stephenville
825	Corner Brook Long Term Care, Corner Brook
826	J.I. O'Connell, Corner Brook
828	Bay St. George Long Term Care Facility, Stephenville Crossing
877	Deer Lake Clinic, Deer Lake
884	Ramea Medical Clinic, Ramea
920	Francois Clinic, Francois

Appendix H

VIRTUAL HEALTH

APPROVED TELEMEDICINE SITES

Facility Number	Telemedicine Site Name
Labrador-Grenfell Integrated Health Authority	
141	Dr. Charles S. Curtis Memorial Hospital, St. Anthony
159	Capt. William Jackman Memorial Hospital, Labrador City
167	Labrador Health Centre, Happy Valley-Goose Bay
834	Community Health Centre, Forteau
863	Labrador South Health Centre, Forteau
864	Straits of Belle Isle Health Centre, Flower's Cove
865	White Bay Central Health Centre, Roddickton
867	Churchill Falls Clinic, Churchill Falls
868	Nain Nursing Station, Nain
894	Mary's Harbour Nursing Station, Mary's Harbour
896	Natuashish Nursing Station, Natuashish
898	Hopedale Nursing Station, Hopedale
908	St. Lewis Community Clinic, St. Lewis
909	Groswater Bay Clinic, Rigolet
910	Postville Community Clinic, Postville
911	Port Hope Simpson Community Clinic, Port Hope Simpson
912	Makkovik Community Clinic, Makkovik
913	Charlottetown Nursing Station, Charlottetown
914	Black Tickle Nursing Station, Black Tickle
915	Cartwright Nursing Station, Cartwright

CRITICAL CARE

ICU AND CCU

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Level A: Infant in Neonatal Intensive Care Unit maintained by artificial ventilation (all modalities) and with full invasive monitoring and parenteral alimentation.		
51730	- first day	435.56
51732	- 2 nd to 10 th day (inclusive), per diem	217.70
51734	- 11 th day onwards, per diem	108.86
Level B: Infant in Neonatal Intensive Care Unit requiring full monitoring both invasive and non-invasive with O ₂ administration and IV therapy but without Ventilatory Support		
51738	- first day	281.62
51740	- 2 nd day onwards, per diem	79.64
Level C: Infant in Neonatal Intensive Care Unit requiring O ₂ administration and non-invasive monitoring and gavage feeding		
51744	- first day	188.85
51746	- 2 nd day onwards, per diem	39.39
Concurrent Care (NICU)		
51790	Physician rendering care concurrently with the physician in-charge, per diem	28.60

CRITICAL CARE

ICU AND CCU

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Comprehensive Care: is the service rendered by an Intensive Care physician who provides complete care (both Critical Care and Ventilatory Support to Critical Care Area patients)		
51750	- first day	342.75
51752	- 2 nd day to 10 th day, per diem	171.37
51754	- 11 th day onwards, per diem	85.69
Critical Care: is the service rendered by a physician for providing, in a Critical Care Area, all aspects of care of a critically ill patient excluding Ventilatory Support		
51756	- first day	232.74
51758	- 2 nd to 10 th day, per diem	116.38
51760	- 11 th day onwards, per diem	58.20
Observatory Care: ICU or CCU patient without invasive monitoring and without assisted ventilation		
51766	- first day	132.00
51768	- 2 nd day to 10 th day, per diem	66.00
51770	- 11 th day onwards, per diem	32.99
Ventilatory Support: is the provision of Ventilatory Care by a physician other than the one claiming Critical care. It includes assessment of the patient and use of artificial ventilator and all necessary measures for its supervision		
51774	- first day	110.00
51776	- 2 nd day to 10 th day, per diem	54.99
51778	- 11 th day onwards, per diem	27.50
Concurrent Care (ICU, CCU)		
51790	Physician rendering care concurrently with the physician in-charge, per diem	28.60

CRITICAL CARE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
CARDIO-PULMONARY RESUSCITATION		
Cardiac Arrest		
51820	First unit (0 to 15 minutes or any portion thereof)	61.70
51822	Subsequent units (each subsequent 15 minutes or part thereof)	28.44
	<p>(1) <i>Units are timed from the onset of the arrest and the presence of the physician.</i></p> <p>(2) <i>A maximum of three physicians will be paid for each time unit.</i></p> <p>(3) <i>The unit fees include all necessary resuscitative measures, e.g., defibrillation, cardioversion, cut-down, etc.</i></p>	
PROVINCIAL PERINATAL HIGH RISK UNIT		
Physician in Charge		
51920	- first day	101.44
51922	- subsequent days	46.93
Concurrent Care (ICU, CCU, Provincial Perinatal High Risk Unit)		
51790	Physician rendering care concurrently with the physician-in-charge, per diem	28.60

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
54000	Visit for diagnostic and therapeutic service(s) only	4.60	
ALLERGY			
54004	Acute desensitization; e.g., ATS penicillin	4.91	
54006	Direct nasal tests, (maximum of 3 tests)98	
54008	Hyposensitization, (1 or more injections) visit fee and/or fee code 54000 not payable in addition	13.08	
54016	Ophthalmic tests, (maximum 5 tests)98	
54018	- quantitative	7.85	
54020	Passive transfer tests	28.34	
54022	Patch test, (maximum 65 tests)	2.00	
Note:			
Patch testing may only be claimed when performed according to generally accepted criteria.			
Provocative Testing			
54026	High-risk provocative testing (must be done in a hospital)	213.25	
54027	- after the first hour, per quarter hour or major part thereof, add	30.00	
54028	Low-risk provocative testing (may be done in a hospital or office)	139.78	
54029	- after the first hour, per quarter hour or major part thereof, add	19.11	
Notes:			
1. No visit or consultation fees can be charged in addition to 54026, 54027 or 54029 . Consultation fee codes 101 and 401 may be billed with fee code 54028 as long as all applicable General Preamble Section 6 criteria for billing are met.			
2. Fee Code 54000 cannot be billed with any of the fee codes for provocative testing (54026 through 54029).			
3. Billing of provocative testing (codes 54026 and 54029) is restricted to only those physicians certified by the Royal College of Physicians and Surgeons of Canada in Clinical Immunology and Allergy. Other physicians providing this service in a hospital may be considered for billing these fee codes upon request to the Assistant Medical Director.			
4. Fee code 54027 can be billed to a maximum of three hours or twelve units. 54029 can be billed to a maximum of two hours or eight units.			
5. Start and end times for fee codes 54026 , 54027, 54028 and 54029 must be documented in the record of service.			
54030	Repository therapy, per injection	75.00	
54032	Scratch/intradermal skin tests, per series (maximum of two series)	43.92	
54033	- for third series, add	25.41	
Notes:			
1. There is a maximum of three series total per visit.			
2. Skin tests must fall into one of six series: indoor aeroallergens, outdoor aeroallergens, food allergens, latex, medication, and venom.			

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
ANAESTHESIOLOGY/THERAPEUTIC			
54054	Hypothermia (therapeutic) induction and management	62.07	
Nerve Blocks			
	1. Fees listed in the FP or Spec. columns must be coded as capacity "0" on claims.		
	2. These codes may not be used when claiming for a procedural anaesthetic except for fee code 54150.		
	3. Anaesthetic time units to <u>not</u> apply unless specified.		
	4. When alcohol or other sclerosing solutions are used, <u>add 50%</u> to the appropriate nerve block fee as listed with the exception of 54130, 54132, 54134 and 54150.		
	5. Therapeutic Anaesthesiology services provided in approved organized hospital pain clinics <u>must</u> be billed using the applicable fee code listed in the In-Hospital Diagnostic and therapeutic services Section of this Payment Schedule.		
54060	Arnold's	55.10	
54062	Brachial Plexus	54.65	
54064	Coeliac Ganglion	106.80	
54066	Epidural/Spinal Block	75.10	
54067	Introduction of intraspinal narcotic (<u>not</u> to be billed in addition to spinal anaesthesia)	49.70	
54068	24-hour monitoring of spinal narcotic given for analgesia	59.64	
54072	Gasserian Ganglion	55.10	
54073	Intraleural Block - single injection	44.25	
54074	- with the introduction of a catheter for the purpose of continuous analgesia	77.25	
54076	Ilioinguinal and iliohypogastric nerves	54.65	
54078	Infraorbital	34.20	
54080	Intercostal nerve root	34.20	
54082	- for each additional one	16.95	
54084	Intrathecal Spinal	75.10	
54086	Lumbar, sacral and coccygeal nerves	34.20	
54088	Mandibular	75.10	
54090	Mental branch of mandibular nerve	34.20	
54092	Occipital	34.20	
54094	Other cranial nerve blocks	84.00	
54096	Paravertebral nerve block of thoracic and lumbar roots – each (maximum of 4 units)	54.65	
54098	Pudendal	54.65	
54102	Sciatic nerve	54.65	
54106	Single somatic nerve	69.30	
54108	Spheno-palatine ganglion	55.10	
54110	Splanchnic	55.10	
54112	Stellate ganglion	55.10	
54114	Supraorbital	34.20	
54116	Sympathetic block (lumbar or thoracic)	64.08	
54118	- bilateral	85.44	
54120	Transverse scapular nerve	55.10	
54122	Intravenous injection and infusion with lidocaine for the treatment of chronic pain	55.10	
54124	Auditory ganglion	55.10	

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
ANAESTHESIOLOGY/THERAPEUTIC (Cont'd)			
Nerve Blocks (Cont'd)			
54126	Femoral nerve - unilateral	54.65	
54128	- bilateral	81.95	
54130	Intrathecal or epidural injection of phenol in iodized oil	165.50	
54132	Introduction of epidural catheter for relief of pain, institution		5
54134	Maintenance: claim 1 unit for each subsequent injection or ¼ hour of maintenance; maximum 12 units per day, per unit		1
54138	Lateral femoral cutaneous nerve	55.10	
54140	Lumbar sympathetic chain	85.44	
54142	Maxillary nerve at its foramen	64.08	
54144	Maxillary or mandibular division of trigeminal nerve	75.10	
54146	Obturator nerve - unilateral	54.65	
54148	- bilateral	82.45	
54150	Retrobulbar, femoral, sciatic, ilioinguinal, iliohypogastric, ulnar, median radial, stellate ganglion block for local anaesthetic purposes or epidural for delivery block	57.06	
54152	Retrobulbar injection of alcohol for acute glaucoma	34.20	
54154	Trigeminal ganglion	84.75	
54156	Superior laryngeal nerve	34.20	
54158	Epidural blood patch	75.10	
54160	Insertion of catheter to provide sustained regional nerve block for relief of pain (Rate payable for insertion is <u>50%</u> of the fee for the appropriate nerve block – claim also the fee code and fee for that nerve block). (Applicable nerve block fee code <u>must</u> be indicated in the comments section and it <u>must</u> be billed as IC giving this information)		
54162	Maintenance of sustained regional nerve block – per half hour to maximum of 3 hours per day	13.78	
54164	Intubation – not associated with anaesthesia	55.10	
<p>Patient controlled analgesia is an acute pain management modality utilized in lieu of traditional intramuscular narcotic injection for pain management. It allows the patient to exercise control of their acute pain. Initiation of PCA involves patient assessment, education, and the actual activation of the PCA apparatus by an Anaesthesiologist. Maintenance of PCA involves 24-hour coverage of patients on PCA. This includes visits and telephone consultation by same or different Anaesthesiologist.</p> <p>Initiation or maintenance of PCA is <u>only</u> payable once per day, same or different Anaesthesiologist. Also, it is <u>not</u> payable in addition to a consultation, visit, ICU or hospital care by the same Anaesthesiologist. PCA services are payable to the same Anaesthesiologist on the same service date as general anaesthesia if at a separate session.</p>			
Patient Controlled Analgesia (PCA) – for parenteral control of acute pain			
54166	- initiation	60.00	
54167	- maintenance	30.00	
Intravenous Ketamine Infusions for Post-Operative Pain			
54170	Initiation of intravenous injection and infusion with ketamine for the treatment of of acute post-operative pain	55.10	
54171	Maintenance of intravenous injection and infusion with ketamine for the treatment of acute post-operative pain, per day	31.45	

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	FP/ Spec.	Anaes.
------	--------------	--------

Notes:

1. These fee codes are billable only for post-operative patients admitted to the hospital.
2. Fee codes 54170 and 54171 cannot be billed on the same calendar day.

For Fee code 54170:

3. Fee code 54170 is billable in addition to applicable anaesthesia surgical time units, visit fee codes, the ROSA stipend, premium fee codes, applicable "Nerve Blocks" fee codes in the Diagnostic and Therapeutic Services section of the Schedule (i.e. fee codes 54060-54067, 54072-54120, 54124-54150, 54154-54156, 54160), and Patient controlled analgesia fee code 54166. Please note that there are pre-existing rules in the Schedule that may prevent billing of multiple services above.

For Fee code 54171:

4. Fee code 54171 is billable in addition to fee codes 54134 ("Maintenance, epidural"), 54162 ("Maintenance, sustained regional nerve block"). Patient controlled analgesia fee code 54167 and the ROSA stipend. Please note that there are pre-existing rules in the Schedule that may prevent billing of multiple services above.
5. Fee code 54171 is not billable in addition to surgical time units by the same or different anaesthesiologist. Fee code 54171 is not billable in addition to premiums or other visits and consultations by the same anaesthesiologist.
6. Fee code 54171 is billable once per patient per day by the most responsible anaesthesiologist.

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
HYPERBARIC OXYGEN THERAPY (HBOT) – Being in constant attendance with the patient (either inside or outside the chamber) for the time billed to provide hyperbaric therapy, including ongoing monitoring of the patient’s condition and intervening as appropriate.			
Physician in chamber with patient, per dive per patient			
54180	first ¼ hour	83.80	
54182	after first ¼ hour (per ¼ hour or major part thereof)	41.90	
54184	after 2 hours in chamber (per ¼ hour or major part thereof)	83.80	
Physician not in chamber with the patient, per dive per patient			
54188	first ¼ hour	71.85	
54190	after first ¼ hour (per ¼ hour or major part thereof)	35.90	
54192	after 2 hours (per ¼ hour or major part thereof)	71.85	
After Hours Hyperbaric Premiums			
54194	Physician attendance commences between 6:00 p.m. and midnight or on Saturdays, Sundays or Statutory Holidaysadd 46% to total fee claimed per patient		
54196	Physician attendance commences any night between midnight and 7:00 a.m.add 50% to total fee claimed per patient		
Medical Assessments			
54198	Initial medical assessment of a patient referred for HBOT	121.00	
54199	Medical reassessment of a patient undergoing HBOT	36.92	

Notes:

HBOT is not an insured benefit for treatment of some conditions. For a list of currently insured conditions, please see Appendix G.

Fee codes 54184 and 54192 are billable in cases of true emergency only: decompression sickness, arterial air embolism and carbon monoxide poisoning.

When a patient is referred for consideration of HBOT by a physician to another physician qualified to administer HBOT, the second physician may bill fee code 54198 if: i) he or she performs an examination commensurate with the presenting complaint and; ii) he or she advises the referring physician of his or her opinion in writing.

Special visit premium(s), and other separately billable procedures may be claimed on a per patient basis when these services are rendered. Fees listed for HBOT must be coded as capacity “0” on claims.

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
CARDIOVASCULAR			
Vascular Cannulation			
54202	Arterial Puncture	8.20	
54204	Cannulation of artery or central vein	41.27	
54206	Arterial cut down	57.77	
54208	Umbilical artery catheterization (including obtaining of blood sample)	27.25	
54210	Umbilical vein catheterization	9.81	
54212	Insertion of Swan-Ganz catheter (not included in anaesthesiology respiratory or critical care benefits)	159.30	4
54214	- measurement of cardiac output either thermal or dye dilution done at same setting (maximum 2 units payable)	add 28.66	
54218	Therapeutic venesection (phlebotomy)	5.89	
54220	Insertion of permanent feeding line under general anaesthesia (e.g. Hickman or Broviac catheter)	150.84	4
54221	Insertion of subcutaneous port (e.g. Port-a-Cath) by surgical creation of a pocket	237.69	4
54222	Surgical removal of permanent feeding line or catheter	36.34	4
54223	Removal of subcutaneous port (i.e. Port-a-Cath)	111.65	4
54226	Anticoagulant Supervision – long term – per month	15.00	
Blood Transfusions			
Exchange transfusions			
54250	- initial (includes consultation and continuing care)	132.44	
54252	- subsequent	105.95	
54254	- multiple	IC	
54256	Assistant at exchange transfusion	IC	
54258	Indirect transfusion	14.36	
54260	Intra-uterine foetal transfusion	98.10	
54264	Plasmapheresis (includes cannulation) donor cell pheresis (platelets or leukocytes)	9.16	
Therapeutic plasma exchange			
54266	- initial and repeat (maximum of 5 per year), each	60.78	
54268	- more than 5 per year, each	22.89	
54270	Manual plasmapheresis	IC	
Cardioversion			
54274	Cardioversion or defibrillation (maximum 3 per patient, per day)	83.16	5
Cardiac Catheterization			
Notes:			
1. Cardiac catheterization procedures (54280 to 54366) include insertion of catheter (including cutdown and repair of vessels if rendered), catheter placement, contrast injection, imaging and interpretation.			
2. When more than one procedure is carried out by the same physician at one sitting, the additional procedures (codes 54280 to 54366) are to be charged at <u>50%</u> of the listed fees.			
Hemodynamic/Flow/Metabolic Studies			
Right heart			
54280	- pressures only	116.92	5
Left heart			
54284	- retrograde aortic	199.39	5
54286	- transseptal	297.15	5
54288	Dye dilution densitometry and/or thermal dilution studies – coronary flow index benefit covers all studies on the same day (in conjunction with Swan-Ganz insertion use fee code 54214)	54.50	
54290	Oxymetry and/or Fick determination	57.23	

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
CARDIOVASCULAR (Cont'd)			
Hemodynamic/Flow/Metabolic Studies (Cont'd)			
54294	Metabolic studies; e.g., coronary sinus lactate and pyruvate determinations	54.50	
54296	Exercise studies during catheterization	add 54.50	
Angiography			
54310	Angiograms (any number of injections)	86.62	
54312	By-pass graft angiogram (including internal mammary artery implant) - per graft injection	66.50	
54314	Selective coronary catheterization	186.59	5
54316	- with drug interventional studies	add 80.70	
54318	His bundle ECG	83.93	
54320	Specialists assisting at cardiac catheterization	65.40	
54322	Transluminal coronary angioplasty including angiography with or without pressure measurements, per vessel	438.43	5
54324	Coronary angioplasty stent, per stent	add 67.00	
Electrophysiologic Pacing, Mapping and Ablation Includes percutaneous access, insertion of catheters and electrodes, electrocardiograms, intracardiac echocardiograms and image guidance when rendered.			
54330	- atrial pacing and mapping	317.08	
54332	- ventricular pacing and mapping	395.38	
54333	- with the use of an advanced nonfluoroscopic computerized mapping and navigation system ("advanced mapping system") and/or procedure duration >4 hours	690.25	10
Note: 54333 is only eligible for payment when rendered with 54330 or 54332. See Preamble for additional terms and conditions.			
For complex cardiac ablations requiring two Interventional Cardiologists trained in electrophysiology and involving 3D mapping:			
- The assisting Cardiologist may bill the FP surgical assist Dedicated Time Method as set out in the General Preamble (\$31.16 per quarter hour)			
- The specialist assist provision as set out in the General Preamble does not apply			
- Documentation of time spent assisting will be provided upon request			
54334	- catheter ablation therapy	333.99	
54336	- repeated	105.47	
54338	External cardiac pacing (temporary transthoracic) once per 24-hour period (Note: note to be claimed with CPR)	43.92	
54340	Electrophysiologic measurements (includes 1 or all of sinus node recovery times, conduction times and refractory periods). Includes insertion of electrodes	219.75	

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
CARDIOVASCULAR (Cont'd)			
Electrophysiology/Pacing (Cont'd)			
Arrhythmias: Induction of arrhythmias to include programmed electrical stimulation, drug provocation and termination of arrhythmia if necessary, once per patient per 24 hours.			
(Note: CPR <u>not</u> payable with these services)			
54342	- induction of atrial arrhythmias	314.04	
54344	- induction of ventricular arrhythmias	363.63	
54346	Testing of arrhythmia inductability by acute administration of anti-arrhythmia drugs – to a maximum of 2 per 24 hours	140.83	
54350	Insertion of permanent or temporary endocardial electrodes	154.10	5
54352	Repositioning of permanent endocardial electrode (as separate procedure)	323.75	5
54353	Repositioning of temporary endocardial electrode (as separate procedure)	64.25	5
54354	Implantation of pack	119.19	5
54356	Insertion of endocardial electrode and implantation of pack (includes insertion of temporary transvenous lead at same surgical procedure by same surgeon)	323.75	5
54358	Replacement of pack (single or multiple leads)	146.45	5
54360	Intracardiac electrocardiography and/or atrial pacing	54.50	
54362	Atrio-ventricular sequential pacemaker with permanent atrial and ventricular endocardial electrodes	454.55	5
Trans-catheter Aortic Valve Implantation (TAVI)			
54364	TAVI	1,862.76	28
54365	TAVI - Monitoring Transesophageal Echocardiography	505.00	28
Notes:			
1) Fee code 54364 is only payable to an Interventional Cardiologist.			
2) Fee code 54364 is a composite fee that pays the billing physician for all aspects of the TAVI procedure including, but not limited to: patient assessment prior to the procedure; electrocardiograms; insertion of catheters and electrodes; cut-down and repair of vessels; pressure measurements; use of imaging guidance; administration of drugs and angiography. A maximum of one unit is payable per procedure. No other fee code is payable in addition.			
3) A Cardiologist that assists at the procedure may bill the FP surgical assist Dedicated Time Method as set out in the General Preamble (\$31.16 per quarter hour).			
4) The specialist assistant provision as set out in the General Preamble does not apply to fee code 54364.			
5) When transesophageal monitoring of TAVI is performed during the procedure a Level III Echo Trained Specialist (other than the physician billing fee code 54364) may bill Fee Code 54365.			
6) Visit and procedural premiums are not payable in association with TAVI as it is a scheduled procedure.			
7) An Anesthesiologist may bill fee code 54364 (28 basic units), plus time and other fees as normally billed.			
Endomyocardial Biopsy			
54366	Transvenous endomyocardial biopsy	99.19	
Note: Includes insertion of catheter.			

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
CARDIOVASCULAR (Cont'd)			
Vasomotor Syncope Testing			
54368	Tilt Table Testing of Vasomotor Syncope to include arterial cannulation, provocative and blocking drugs (physician must be continually present)	103.00	
Cardiography: (includes technical component)			
54370	Apex	19.62	
54374	Echo	24.53	
54375	Saline study (including venipuncture)	10.83	
54376	Insertion of oesophageal transducer	45.00	
54377	Transoesophageal echocardiography by Anaesthesiologist or other qualified specialist for intraoperative monitoring of cardiac surgery and/or assessment of unexplained hypotension or hemodynamic instability	120.00	
	Note: Fee code 54377 includes payment for echocardiography and cardiac Doppler studies		
54378	Umbilical arterial catheterization - (including obtaining of blood sample)	26.16	
Electrocardiogram			
54380	Office - technical component	9.13	
54382	- professional component	9.27	
54384	Home - technical component	11.84	
54386	- professional component	12.36	
54388	Ballisto cardiogram	21.80	
	Before and after exercise		
54390	- technical component	10.90	
54392	- professional component	10.90	
	Maximal stress ECG or submaximal stress ECG		
54394	- technical component	19.08	
54396	- professional component	30.52	
54397	- dobutamine stress test – when rendered outside of hospital	37.26	add
54400	Dipyridamole Thallium Stress Test	64.75	
54402	12 to 23 hour arrhythmia tapings (interpretation)	30.52	
	Interpretation of telephone transmitted ECG rhythm strip		
54406	- professional component	3.20	
54408	- technical component	1.60	
	Single chamber reprogramming including electrocardiography		
54410	- professional component	8.50	
54412	- technical component	8.50	
	Dual chamber reprogramming including electrocardiography		
54414	- professional component	16.95	
54416	- technical component	11.30	
	Pacemaker pulse wave analysis including electrocardiography		
54418	- professional component	8.50	
54420	- technical component	8.50	
Interrogation, Reprogramming of Automatic Implantable Defibrillator			
54421	Interrogation of automatic implantable defibrillator	27.80	
54422	Interrogation and reprogramming of automatic implantable defibrillator	45.21	

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
CARDIOVASCULAR (Cont'd)			
Interrogation, Reprogramming of Automatic Implantable Defibrillator (Cont'd)			
Notes:			
	1. The fees for codes 54421 and 54422 include payment for electrocardiography.		
	2. Fee code 54421 can be billed when a Cardiologist or Internist with appropriate training situated in a hospital performs remote interrogation of an automatic implantable defibrillator. It can also be billed when a patient presents to a hospital and a Cardiologist or Internist with appropriate training interrogates an automatic implantable defibrillator but does not reprogram the device.		
	3. Fee codes 54421 and 54422 are not payable for the same patient on the same date.		
Hospital Vascular Laboratory Fees			
54425	Ankle pressure determination – not chargeable during surgery or during the patient's post-operative stay in hospital	9.64	
54426	Ankle pressure measurements with segmental pressure recordings and/or pulse volume recordings and/or Doppler recordings	27.14	
54427	Ankle pressure measurements with exercise and/or quantitative measurements added to above	11.75	
Venous Evaluation – Duplex Scan i.e. Simultaneous Real Time B-Mode Imaging for Suspected DVT, or for Evaluation for Dialysis Grafting, or for Suspected Thrombosed Dialysis Graft			
54428	- interpretation	16.75	
54429	- procedure	28.48	

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
DERMATOLOGY			
	Laser Treatment of Insured Vascular Lesions		
54430	First ½ hour portion thereof	135.58	
54432	Each additional 15 minutes after the initial ½ hour	add 67.79	

Laser treatment of specific congenital vascular malformations is billable according to the rules listed below. Laser treatment of pigmented congenital lesions such as naevi, café-au-lait spots, etc., is not an insured service.

GENERAL RULES

- (a) A visit fee is not payable in addition to the listed fees.
- (b) All congenital vascular lesions with the exception of spider naevi, in children less than 18 years of age, are insured.

INSURED VASCULAR SKIN LESIONS

The following outlines, either by diagnosis and/or criteria, eligibility for MCP payment for the laser treatment of vascular skin lesions:

By diagnosis:

Blue Rubber Bleb Syndrome – Bill using remarks code 28.

By diagnosis, age and site:

- Port Wine Stains – Bill using remarks code 26.
- Angiofibromas of Tuberous Sclerosis – Bill using remarks code 29.
 - Insured if age 18 and under;
 - Insured after age 18 only if on the face and/or neck.

By diagnosis, age and medical necessity:

- Strawberry haemangiomas – Bill using remarks code 27.
- Cherry haemangiomas – Bill using remarks code 30.
- Haemangio-lymphangiomas – Bill using remarks code 31.
- Arterio-venous malformations – Bill using remarks code 33.
 - Insured if age 18 and under;
 - Insured after age 18 only if medical necessity, as defined by MCP, is met.

Laser treatment of all other vascular lesion not listed above:

To be eligible for MCP payment, the laser treatment of all other vascular lesions must meet the definition of medical necessity, as defined by MCP.

MEDICAL NECESSITY – DEFINITION

Medical necessity is defined as significant impairment of function (eye, nose or mouth), chronic skin ulcerations(s), soft tissue hypertrophy and/or recurrent bleeding, which is refractory to standard medical treatments.

- This excludes either a single episode of bleeding or episodes of bleeding that are widely spaced in time and respond to standard medical treatment, such as bandaging or medications (topical or oral).

For each lesion treated with laser, the condition of medical necessity must be met.

PRE-AUTHORIZATION

To be eligible for payment from MCP, all requests related to the laser treatment of vascular lesions must be preauthorized by either the Director or Assistant Medical Director of **Medical Services**.

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
	DIALYSIS: team fees to include listed items. (This does not include preliminary investigation of the case)		
	Haemodialysis		
54450	Initial acute (to include surgical components)	584.88	
54452	Repeat acute	198.82	
54454	Insertion of Cannula or Scribner Shunt (included in the initial fee)	158.05	6
54456	Medical component (included in the initial fee)	426.83	
54458	Chronic	65.00	
	Management of cannula, shunt, or by pass-graft		
	Revision of Cannula or Scribner Shunt		
54460	- single	61.04	4
54462	- both	87.20	4
54464	De-clotting of Cannula or Scribner Shunt	53.46	
54465	Removal of cannula or AV shunt	72.00	4
54466	By-pass graft for haemodialysis – complete surgical care	290.54	7
	Peritoneal dialysis		
54480	Acute (up to 48 hours) – includes stylette cannula insertion (temporary)	198.82	
54482	Repeat acute	198.82	
54484	Chronic – maximum of 2 per week	56.14	
	Management of peritoneal cannula or catheter		
54486	Insertion of peritoneal cannula by laparotomy or laparoscopy – complete surgical care	256.10	6
54487	Removal of peritoneal cannula by laparotomy or laparoscopy – complete surgical care	256.10	6
54488	Insertion of Tenckov type peritoneal catheter – chronic – by trocar	154.40	4
54490	Removal of Tenckov type peritoneal catheter	63.10	4
	Home Dialysis		
54492	Monthly retainer for administration and supervision	181.82	
	Claim date <u>must</u> be last date of each completed month of supervision.		
	Satellite Haemodialysis		
54494	Weekly fee for administration and supervision of Satellite Haemodialysis patients, per patient	75.00	
	Notes:		
	1. Fee code 54494 is the benefit for managing chronic haemodialysis where the patient undergoes dialysis at a HCS approved satellite site remote from the site where the billing physician is located.		
	2. For the purpose of claiming this code “remote” means patient and physician are located in different municipalities and the physician does not attend the patient’s dialysis sessions at the satellite site in person.		
	3. All claims for fee code 54494 must include the facility number of the satellite site where the patient is located. See the MCP Physician Information Manual for a list of numbers.		
	4. For MCP billing purposes, the claim date must be the last date of each completed week of supervision where a week begins 12:00 a.m. Monday and ends 11:59 on Sunday.		
	5. If the billing physician provides in person dialysis services to the patient at the satellite site, the amount that can be claimed for code 54494 that week must be reduced by 50%		
54496	Teledialysis assessment with patient, once per week, per patient	65.00	

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
ENDOCRINOLOGY AND METABOLISM			
54500	Antidiuretic hormone response test	14.72	
54502	Basal metabolic rate	9.81	
54504	Benzodioxine test	9.81	
54514	Histamine test	11.99	
54518	Implantation of hormone pellets	11.99	
54520	Insulin sensitivity test	26.16	
54526	Pentagastrin Stimulation for calcitonin	37.80	
54532	Rogetine test	11.99	
54538	Water tolerance test	11.99	
GASTROENTEROLOGY			
54550	Oesophageal tamponade (insertion of Blakemore bag)	44.36	
54552	Oesophageal motility test	65.40	
	Oesophageal pH study for reflux		
54560	- adult	24.53	
54562	- paediatric	45.00	
54563	- with 24-hour pH monitoring add	5.50	
54564	Oesophageal potential difference test	24.53	
54566	Oesophageal perfusion test	21.80	
54568	Duodenum aspiration – by intubation for secretion test (after 1 hour, charge detention extra)	11.99	
	Gastric lavage:		
54570	- diagnostic	6.54	
54572	- therapeutic	20.71	
	Gastric secretion studies (Augmented Histamine or Histalog, or Pentagastrin)		
54576	- procedure, supervision and interpretation	18.53	
54578	Combined pH and motility test	73.58	
54580	Combined pH motility and potential difference test	88.29	
54582	Fluorescent string test for gastro intestinal bleeding	24.53	
54584	Ano-rectal manometry	45.30	
54586	Capsule endoscopy	342.10	

Notes:

1. Payable for review of imaging done in hospital and report to the referring physician.
2. A visit cannot be claimed at the same sitting as the initiation of capsule endoscopy.
3. Fee code 54586 is only insured for patients who have previously undergone some or all of the following: esophagogastroduodenoscopy, colonoscopy, small bowel enteroscopy and/or small bowel series radiography & fluoroscopy.

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
FAMILY MEDICINE			
Opioid Agonist Maintenance Therapy – Monthly stipend for overseeing patients on opioid agonist treatment (OAT).			
54596	Per patient, once per month	70.00	
Notes:			
1. OAT means the administration of methadone or buprenorphine/ naloxone (Suboxone) for opioid dependency.			
2. For physicians working in a primary care setting who are managing patients in the induction, stabilization, and/or maintenance phases of OAT.			
3. Entitlement to this monthly stipend is limited to physicians who:			
(a) prescribe methadone or buprenorphine/naloxone for addiction; and			
(b) are actively supervising the patient’s continuing use of methadone or buprenorphine/naloxone.			
4. Only one physician will be paid the monthly stipend.			
5. Visits for each patient contact would be paid as at present.			
6. Not eligible for premiums or surcharges.			
7. This payment stops when the patient stops taking methadone or buprenorphine/naloxone.			
54598	Ear syringing – uni or bilateral	5.00	4
Note: May be billed for services rendered in office, home or hospital settings.			
GYNECOLOGY			
54600	Artificial insemination	17.20	
54606	Huhner’s test	8.18	
54607	Medical Abortion	187.49	
Note: Fee code 54607 is a comprehensive fee which is billed one-time only when a physician prescribes a medication for medical abortion. This fee then includes all services associated with providing the medical abortion including: the consultation and/or visit during which the medication is prescribed; counselling; ordering and/or performing and/or interpreting of laboratory tests and diagnostic imaging; any follow-up communications or visits.			
This fee may be billed for services rendered in office, home, hospital, or other health care facilities.			
54614	Speculum exam (no charge if done as part of the following : consultation, repeat consultation, general or specific assessment, routine post-natal visit, or surgical procedure requiring the use of a speculum)	19.25	
54618	Pessary check	10.00	
Note: May be billed for services rendered in office, home or hospital settings.			

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
INJECTIONS OR INFUSIONS			
	Lateral discography		
54626	- lumbosacral disc as first disc.....	76.68	4
54628	- any other disc as first disc.....	40.06	4
54630	- second and subsequent discs, each	20.60	
	Injection of chemonucleolysis		
54632	- initial injection	11.45	
54634	- any subsequent injection at other levels, each	5.72	
54636	Injection of extensive keloids	20.50	
54638	- under general anaesthesia	37.50	4
54640	BCG inoculation, including tuberculin tests	5.45	
54644	Injection of bursa, joint or tendon sheath (not to be billed in addition to same site surgical benefits when performed at time of surgery), including preliminary aspiration	24.77	
54646	- each additional site or area (maximum 8 injections per visit)	19.90	
54648	Adult immunization for target populations as described in Appendix D	17.16	
54649	Adult immunization for target populations as described in Appendix D add-on to office visit	10.00	
	Botulinum Toxin Injection for the following conditions: Oromandibular dystonia, limb dystonia, cervical dystonia or spasticity, hemifacial spasm, blepharospasm		
54652	- first injection	45.00	
54654	- each additional injection to a maximum of 11, to 54652	10.00	
	Intradermal, intramuscular or subcutaneous – with visit – first injection	NC	
	(NC=No Charge)		
54656	- each additional injection	1.31	
	Intradermal, intramuscular or subcutaneous sole reason		
54658	- first injection	2.62	
54656	- each additional injection	1.31	
54660	Intralesional infiltration (1 or more lesions)	14.92	
Intravenous			
No fee is payable for injections into an established IV apparatus.			
54664	Newborn or infant	11.01	
54666	- scalp vein	15.36	
54668	- cut down	20.26	
54670	Child, adolescent or adult	4.02	
54674	- cut down	19.01	

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
INJECTIONS OR INFUSIONS (Cont'd)			
<p>Chemotherapy with each injection supervised by a physician for intravenous infusion for treatment of malignant or autoimmune disease. Physicians must be physically present in the clinic in which the injection is administered, at the time of injection and for the duration of the infusion and must during all of that period be available to intervene immediately, if required.</p> <p>Chemotherapy and patient assessment provided by physician <u>in hospital based clinics or to in-patients</u>. The following benefits include patient assessment for a 24-hour period, drug administration, venipuncture, and establishment of any vascular access line.</p> <p>Note:</p> <ol style="list-style-type: none"> 1. Fee codes 54688, 54690, 54692 and 54696 are only eligible for payment with respect to the following classes of biologic agents: <ol style="list-style-type: none"> a. monoclonal antibodies; and b. cytokines 2. Examples that are not considered biologic agents for payment purposes are blood products, insulin and immunizing agents. 			
54688	Standard chemotherapy – agents with minor toxicity that require physician monitoring	59.68	
54690	- each additional standard chemotherapy agent, other than initial agent add	8.47	
<p>Note: Examples of standard chemotherapy agents include cyclophosphamide, methotrexate, fluorouracil, leucovorin and zoledronic acid.</p>			
54692	Complex single agent or multi-agent therapy – chemotherapy and/or biologic agent(s) that can cause vesicant damage, infusion reactions, cardiac, neurologic, marrow or renal toxicities that may require immediate intervention by the physician	82.50	
<p>Note: Examples of complex single agents include rituxamib, bevacizumab, trastuzumab, anthracyclines, bortezomib, taxanes, cisplatin and etoposide fludarabine.</p>			
54696	Special single agent or multi-agent chemotherapy and/or biologic agent(s) with major toxicity that require frequent monitoring and prolonged administration periods and may require immediate intervention by the physician	115.67	
<p>Note: Examples of special agent therapy include high-dose methotrexate with folinic acid rescue, methotrexate given in a dose of greater than 1 g/m², high dose cisplatin greater than 75 mg/m² given concurrently with hydration and osmotic diuresis, high dose cytosine, arabinoside (greater than 2 g/m²) high dose cyclophosphamide (greater than 1 g/m²), ifosfamide with MENSA protection, combination of biologic agents with complex chemotherapy.</p>			

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
INJECTIONS OR INFUSIONS (Cont'd)			
Management of Special Oral Chemotherapy			
<p>This is the service for the supervision of oral chemotherapy treatment for malignant disease where the agent(s) has a significant risk of toxicity in the period immediately following initiation. The physician must be available to intervene in a timely fashion for a 24-hour period following the initiation of the treatment.</p> <p>In addition to the Common Elements in this Schedule, this service includes the provision of the following services to the same patient:</p> <ul style="list-style-type: none"> (a) evaluation of any relevant laboratory, diagnostic and/or imaging investigations; and (b) all discussion or advice, whether by telephone or otherwise, involving the patient, staff, patient's relative(s) or patient's representative related to the oral chemotherapy for a period of one month following initiation of the agent(s). 			
54698	Management of special oral chemotherapy for malignant disease		22.55
Notes:			
<ul style="list-style-type: none"> 1. 54698 is not eligible for payment for the same patient in the same month where 54700 is payable. 2. 54698 is only eligible for payment once every month. 3. Examples of special oral chemotherapy include fludarabine, imatinib, dasatanib, nilotinib, erlotinib, capecitabine, sunitinib, sorafenib, thalidomide, temazolamide and lenalidomide. 			
54700	Supervision of oral or intramuscular chemotherapy (pharmacologic therapy of malignancy or autoimmune disease) – monthly		14.63
54702	Pneumothorax - initial		15.82
54704	- subsequent		15.82
54706	Pneumoperitoneum - initial		15.82
54708	- subsequent		9.81
Varicose veins (per visit)			
54710	- single injection.....		5.45
54712	- two or more injection (unilateral or bilateral).....		7.63

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
NEUROLOGY			
54800	Electrocorticogram – supervision and interpretation	153.75	
	Electroencephalography		
54802	- complete procedure	28.89	
54804	- interpretation	11.45	
54806	- with activating drugs; e.g., megamide	11.45	add
54808	- inserting subtemporal needle electrodes	11.45	add
54810	- attendance and supervision of ECG during major surgery	114.45	
54816	- tensilon testing	18.00	
54820	Amytal test – bilateral – supervision and coordination of tests	62.95	
OPHTHALMOLOGY			
54846	Intravitreal injection of anti-VEGF substance (unilateral) 1 unit per eye, 2nd eye to be billed at 85%	175.00	
54848	Ocular Coherence Tomography in association with intravitreal injection of anti VEGF substance in office (uni-or bilateral)	30.00	add

Notes:

1. The above fee codes are insured for treatment and examination of neovascularization associated with: macular degeneration, diabetic macular edema, and retinal venous occlusion.
2. A maximum of one unit of IVI is payable per eye regardless of the number of injections.
3. If both eyes are injected, the second eye should be billed at 85% of the listed rate.
4. A maximum of one unit of office OCT is payable per patient treatment session regardless of the number of injections.
5. The office OCT fee code is only payable as an add-on to IVI; it is not payable as an add-on to any other fee code and is not payable when billed alone.
6. Intravitreal injection of anti-VEGF is not payable when delegated to another health care professional, physician employee, or assistant when provided in a clinic outside of the hospital setting.
7. Payment for the use of topical or local anaesthesia will be included in the fee for IVI.

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
OPHTHALMOLOGY (Cont'd)			
Contact lens fitting is <u>not</u> an insured service except for the following conditions:			
	(a) Aphakia, monocular and binocular		
	(b) high myopia, greater than nine (9) dioptres		
	(c) irregular astigmatism (post-corneal grafting or corneal scarring resulting from disease states), and		
	(d) keratoconus		
Note:			
Fee codes 54850, 54852 and 54854 <u>must</u> be billed IC indicating the condition for which the procedure was done.			
54850	Contact lens fitting (with follow-up for 3 months)	156.90	
54852	One eye only, when the other eye has been previously fitted by the same physician (with follow-up for 3 months)	80.80	
54854	Hydrophilic "Bandage" lens fitting	90.30	
Note:			
Fee code 54000 will not apply for fee code 54860 to 54896			
54860	Intravenous fluorescein angiography – professional and technical component	58.88	
54864	Glaucoma provocative tests, including water drinking tests	17.44	
54868	Ophthalmodynamometry	5.45	
54870	Orthoptics (assessment or treatment)	6.28	
	Radioactive phosphorous examination		
54872	- anterior approach	28.89	
54874	- posterior approach	57.77	
54876	Sonography	42.67	
54877	Fundus photo, technical fee and retinophoto interpretation	20.00	
54878	Static perimetry (uni or bilateral)	40.21	
54880	Tonography (to include tonometry)	12.26	
54882	- with water	17.44	
54884	Tonometry (uni or bilateral)	10.27	
	(not to be charged if done in conjunction with an ophthalmological consultation, specific assessment or reassessment)		
54888	Subconjunctival or sub-Tenons capsule injection	14.30	
54896	Botulinum toxin injection of extra ocular muscle with electro-myographic control, per muscle	75.00	

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	FP/ Spec.	Anaes.
------	--------------	--------

OPHTHALMOLOGY (Cont'd)

Ocular Photodynamic Therapy (PDT) – is, subject to the limitations set out below, an insured service when rendered by an Ophthalmologist. PDT includes retinal photography, establishment of intravenous access, supervision of drug infusion and personal application of non-thermal diode laser for activation of verteporfin.

PDT is insured only if the patient’s clinical condition meets all of the following criteria:

- (i) the patient has predominantly classic subfoveal choroidal neovascularization (CNV) secondary to either age-related macular degeneration (AMD) or occult or ‘minimally classic’ AMD less than 4 disc diameters. ‘Predominantly’ means that the area of classic subfoveal CNV is equal to or greater than 50% of the total CNV lesion, as determined by fluorescein angiography and documented by retinal photographs;
- (ii) treatment is commenced within 12 months after initial diagnosis of predominantly classic subfoveal CNV secondary to either AMD or occult or ‘minimally classic’ AMD less than 4 disc diameters;
- (iii) the patient’s visual acuity is equal to or worse than 20/40; and
- (iv) for each repeat therapy, recurrent or persistent CNV leakage is detected by fluorescein angiography and documented by retinal photographs.

Retinal photographs must be made prior to the procedure and permanently retained. Maximum one PDT (unilateral or bilateral) per patient, per day.

54897	- unilateral PDT per patient, per day	300.00
54898	- bilateral PDT per patient, per day	375.00

Notes:

- 1. Intravenous injection fee codes are not payable for the same patient on the same date as fee codes 54897 and 54898.
- 2. Fee codes 54897 and 54898 cannot both be claimed for the same patient on the same date.
- 3. Assessments and angiography are payable in addition to PDT. Retinal photography is insured as a specific element of the assessment and is not payable separately.

54899	Remote Retinophoto interpretation	9.44
-------	---	------

Notes:

- 1. For remote use only
- 2. No visit code is billable in addition to 54899
- 3. Maximum one unit per patient (unilateral or bilateral) per month
- 4. Maximum of 25/week per Ophthalmologist

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
OTOLARYNGOLOGY			
54900	Particle repositioning manoeuvre for benign paroxysmal positional vertigo	19.49	
Audiometric tests			
Fee code 54000 will <u>not</u> apply for fee codes 54906 and 54910			
Pure tone air and bone conduction			
54906	- professional component	4.50	
54910	- professional component with speech tests	13.93	
Impedance audiometry			
54916	- professional component	8.17	
Advanced testing (may include recruitment sisi, tone decay, malingering, Bekesy test) (per test to a maximum of 2 tests)			
54924	- professional component	5.00	
Hearing aid evaluation, including pure tone air and bone conduction and speech tests			
54932	- professional component	2.45	
Cortical audiometry			
54940	- professional component	15.40	
Vestibular function tests			
Caloric testing with electronystagmography			
54952	- professional component	16.80	
Minimal caloric			
54954	- professional component	4.58	
Fitzgerald-Hallpike method			
54956	- professional component	14.44	
Electronystagmography			
54960	- professional component	14.10	
Electrogustometry			
54962	- professional component	9.27	

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
PHYSICAL MEDICINE			
54970	Nerve stimulation	22.89	
Therapeutic Procedures			
54976	Manipulation - major joint	7.96	
54978	- minor joint	3.92	
54980	Miscellaneous therapeutic procedures not exceeding one hour as listed below	5.00	
	- Intermittent positive pressure breathing treatments (office)		
	- Heat-diathermy, heat cabinets, heat cradles or bakers, radiant heat, whirlpool baths, paraffin baths, microtherm, etc.		
	- Pulsed-diathermy Light-Ultraviolet – general, local, orifical, etc.		
	- Electrotherapy – Galvanic, Faradic and sinusoidal currents, iontophoresis, etc.		
	- Ultrasound		
	- Hydrotherapy – contrast baths – hotpacks; Local (arm and leg, whirlpool baths): general (Hubbard) for body immersion or Body Tanks; therapeutic pool, under water exercises, cryotherapy		
	- Mechano Therapy – massage, mechanical device traction, pulleys and weights, treadles stationary bicycles, shoulder wheels		
	- Therapeutic Exercise		
	- Occupational Therapy – Programme adapted to individual’s needs		
	- Activities of daily living (ADL) functional and supportive programme, woodwork, metal, leather, basketry, looms, etc.		
	- Inhalation Therapy		
	Thermography of hand, foot or large joint – 1 or more areas		
54982	- technical component	13.00	
54984	- professional component	6.50	

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
PSYCHIATRY			
54990	ECT	80.30	4
	Charges for hospital visits, home or office fees do <u>not</u> apply on a day when ECT or individual psychotherapy is charged. (same diagnosis, same physician)		
UROLOGY			
55024	Cystometrogram and/or voiding pressure studies (micturition studies)	56.72	
55034	Prostatic massage	5.78	
55036	Penile pressure recordings – 2 or more pressures	9.64	
VENIPUNCTURE			
55040	Newborn or infant	5.45	
55042	- scalp vein	10.57	
55044	Child, adolescent or adult	6.90	
55046	Therapeutic venisection	6.54	

Finger prick blood sampling is not considered to be a “venipuncture”.

Venipuncture fees are not payable for the office collection of blood if the sample is collected less than 16 kilometers from the nearest hospital or satellite laboratory unless a patient’s illness or disability does not permit him/her to travel to the normal collection site.

**CLINICAL PROCEDURE ASSOCIATED WITH DIAGNOSTIC
RADIOLOGICAL EXAMINATIONS**

This section is for the use of physicians other than Radiologists and those physicians designated by individual hospitals to provide imaging services.

These procedural fees are intended to cover compensation for the professional service of placing an instrument and introducing contrast media (except oral or rectal administration for study of the alimentary tract).

When the following listings involve bilateral procedures, add 50% to the listed fee(s).

Fee code 54000 is not payable in addition to the following procedures:

Code		FP/ Spec.	Anaes.
55050	Arthrogram	17.44	4
55056	Bronchogram	11.45	6
55060	Cerebral angiogram	45.78	5
55064	Dacryocystogram	11.45	4
55066	Discogram	40.33	4
55074	Hypotonic duodenogram	22.89	4
55076	Hysterosalpingogram	50.11	4
55080	Laryngogram	11.45	
55082	Lymphogram	26.16	
55088	Myelogram	26.16	4
55094	Nephrotomogram		4
55106	Percutaneous transphepatic cholangiogram	28.51	4
55108	Peripheral angiogram	17.44	4
55110	Peritoneal pneumogram	17.44	4
55118	Tomogram		5
55120	Urethrocystogram	5.78	
55122	Vasogram	28.89	5
	Thoracic or abdominal angiogram		
	Introduction by		
55140	- translumbar aorto or venogram	45.78	5
55142	- percutaneous arterial or venous needle (or cut-down on superficial peripheral vein)	45.70	5
	- percutaneous arterial or venous catheter (or cut-down on superficial vein)		
55150	- non selective	57.77	5
55152	- selective	87.20	5
	Exposure of major artery		
55154	- non selective	87.20	5
55156	- selective	114.45	5

IN-HOSPITAL DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
ELECTROCARDIOGRAMS		
56000	Electrocardiogram interpretation	9.71
56010	Stress electrocardiogram (physician present during testing procedure) Before and after exercise (Masters criteria, Levy Ischemia or Frasher Exercise test) includes complete resting tracing and multiple leads taken immediately and 3 and 6 minutes post exercise	20.70
56020	Maximal stress testing – with treadmill or ergometer and oscilloscopic continuous monitoring, including ECGs taken during the procedure and resting ECGs before and after the procedure	62.95
Continuous Ambulatory ECG Monitoring		
56050	Interpretation of continuous ambulatory ECG scan	30.91
56060	Partial review of scan and interpretation	37.40
56070	Complete review of scan and interpretation	63.25
Cardiac Loop Monitoring		
56080	Implantation or replacement of loop recorder	119.19
Note: Fee code 56080 includes payment for removal of loop recorder.		
56082	Removal of loop recorder without replacement	54.38
56084	Loop recorder event interpretation and/or reprogramming	12.65
ELECTROMYOGRAPHY AND NERVE CONDUCTION		
56500	Complete procedure, e.g. conduction studies on 2 or more nerves and EMG of multiple muscles; detailed study of neuromuscular transmission	173.39
56525	Limited procedure, e.g. conduction studies on a single nerve plus limited needle electrode examination in 1 area; or conduction studies on 2 nerves without EMG	109.72
56550	Short procedure, e.g. stimulation of a single nerve; or repeat EMG of 1 or 2 muscles without nerve conduction	44.17
56575	Single fibre EMG	128.01
ELECTROENCEPHALOGRAPHY		
57000	Electroencephalogram interpretation	41.16
57010	- with use of sleep inducing drugs and/or sleep deprivation add	35.78
57020	- inserting subtemporal needle electrodes add	28.38
57025	- videotape recording of clinical signs in association with EEG add	33.33
	Polygraphic recording of parameters in addition to EEG, e.g., respiration, eye movement, ECG muscle movement	
57030	- 1 item add	16.21
57035	- 2 items add	32.43
57040	- 3 or more items add	47.21
SLEEP APNEA STUDIES		
57050	Sleep apnea (overnight study) with continuous monitoring of oxygen saturation and ventilation - to include physician attendance at set up, monitoring and interpretation (extra or special visits not chargeable)	223.23
57060	- interpretation only	83.04

IN-HOSPITAL DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
EVOKED POTENTIAL STUDIES		
57500	Simple average evoked potential studies with 1 sensory modality of stimulation (interpretation by physician)	42.69
57510	Complex evoked potential studies involving several sensory modalities, multiple threshold determinations of more than 4 simultaneous channels of recording (partial supervision by physician and interpretation)	53.82
57520	Complex evoked potential studies performed completely under the direct supervision of a physician and interpretation	107.93

DERMATOLOGY

57600	Hospital Phototherapy Unit Supervision (per patient, per week)	10.00
-------	--	-------

Notes:

1. Fee code 57600 is only payable to specialists in Dermatology who have been granted privileges by their Regional Health Authority (RHA) to assess patients and supervise phototherapy treatment provided in a unit operated by the RHA. They must attend the unit regularly to assess phototherapy patients and must respond to inquiries from RHA staff who administer phototherapy treatment when requested.
2. Such Dermatologists will be deemed 'approved Dermatologists' by MCP for payment purposes upon receipt of written notification from the RHA that the applicable privileges have been granted.
3. To be eligible to bill fee code 57600 an 'approved Dermatologist' must review a patient's response to phototherapy treatment in person, or through a direct interactive video link at approved telemedicine sites, with the unit nurse, or other health care provider approved by the RHA, and prescribe changes, or order continuation or termination of the current treatment. Fee code 57600 is not billable before the patient commences phototherapy treatment and is not billable after the patient has completed a course of treatment.
4. Fee code 57600 is payable once weekly per patient if the above conditions are met.
5. When an approved Dermatologist examines a phototherapy patient in the phototherapy unit the Dermatologist may bill the applicable consultation or visit fee code, provided Preamble requirements are met. However, fee code 57600 may not be billed in addition during the same week.
6. Phototherapy unit records will satisfy the documentation requirements for fee code 57600.
7. The institution number for the phototherapy unit must be entered in the 'Hospital No.' field on all claims for fee code 57600.

IN-HOSPITAL DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
NEUROLOGY		
57650	Titration of Levodopa Carbidopa Intestinal Gel (LCIG) for Parkinson’s Disease, per patient per day (maximum 3 units per week)	250.00
	Notes:	
	1. This fee code is currently restricted to Neurologists who 1) possess Royal College of Physicians and Surgeons of Canada certification in Neurology and 2) have successfully completed a Duodopa education program facilitated by the manufacturer (i.e. AbbVie). Neurologists meeting this criteria may contact the Assistant Medical Director for approval for billing this code.	
	2. When Titration of LCIG is billed, no other fee codes can be billed for the patient on that date of service.	
57655	Pre-, Intra- and Post-Operative Management of Deep Brain Stimulator Battery during Operative Battery Replacement. (Includes interrogation of battery, assessing battery level and settings, checking impedances, transfer of settings to the new battery, visit(s) with the patient)	278.85
OBSTETRICS AND GYNECOLOGY		
57700	Non-stress test – interpretation only	9.65
	If the non-stress test is done in conjunction with a consultation, the interpretation is considered to be included in the consultation fee	
Maternal Fetal Medicine (MFM)		
	The fee codes listed in this section can only be billed by MFM Specialists who have been designated by their hospital to provide imaging services.	
	Echography – Scan B-mode, per fetus (bill each additional fetus I.C. at 85% of the listed rate)	
	First trimester scan for viability and dating, transvaginal or transabdominal	
57710	- interpretation	46.22
57711	- procedure	33.36
	Nuchal translucency determination by MFM Specialist (once per pregnancy)	
57712	- interpretation	25.30
57713	- procedure	40.00
	Note:	
	Routine screening of Nuchal translucency without biochemical markers in singleton pregnancies is not an insured service.	
	Placenta localization	
57714	- interpretation	34.20
57715	- procedure	25.00

IN-HOSPITAL DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
OBSTETRICS AND GYNECOLOGY (Cont'd)		
	Transvaginal assessment of cervical length in pregnancy at increased risk for preterm birth by MFM Specialist	
57716	- interpretation	34.20
57717	- procedure	25.00
Note:		
Routine screening of cervical length of pregnancy is not an insured service.		
	Fetal anatomy scan by MFM specialist	
57718	- interpretation	53.20
57719	- procedure	75.00
	Fetal Doppler evaluation of middle cerebral artery, and/or IVC and/or ductus venosus	
57720	- interpretation	31.60
57721	- procedure	32.90
Note:		
These codes are only eligible for payment when rendered by a MFM Specialist for assessment of fetal anemia, intrauterine growth retardation measuring below the 10 th percentile or twin-twin transfusion syndrome.		
	Fetal assessment in-utero for physical condition of the fetus	
57730	- interpretation and procedure	45.60

IN-HOSPITAL DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
OPHTHALMOLOGY		
57780	Ocular Coherence Tomography – interpretation, uni or bilateral	30.00
	Note: This fee code can only be claimed by Ophthalmologists when OCT is performed in the hospital for the following indications: intravitreal injection of anti-VEGF or for evaluation in hospital of macular diseases of the retina or patients with previously documented features of glaucoma such as ocular hypertension, established visual field defects and optic nerve morphology consistent with a diagnosis of glaucoma. Screening of patients with ocular coherence tomography is not an insured service.	
57782	Corneal Pachymetry, uni or bilateral	3.60
	Note: This fee code can only be claimed in hospital once per calendar year per patient, by a maximum of one Ophthalmologist for measurement of corneal thickness in glaucoma patients. Claims by a second Ophthalmologist are not payable unless billed IC with an explanation of the medical necessity for the second measurement. Screening of patients with corneal pachymetry is not an insured service.	
Electro-retinography		
57792	Full field electro-retinography – interpretation	30.00
	Notes: 1. Fee code 57792 is limited to 2 services per patient per 12 month period.	

IN-HOSPITAL DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
ORGANIZED PAIN CLINIC		
Notes:		
1.	These fee codes may <u>only</u> be billed by Anaesthesiologists working in an organized hospital pain clinic approved by the Regional Health Board.	
2.	Fees listed for Organized Pain Clinics <u>must</u> be coded as capacity "0" on claims.	
3.	These codes may <u>not</u> be used when claiming for a procedural anaesthetic.	
4.	Anaesthetic time units <u>do not</u> apply.	
5.	When alcohol or other sclerosing solutions are used, add <u>50%</u> to the appropriate nerve block fee as listed.	
6.	Therapeutic Anaesthesiology services provided in settings other than approved organized hospital pain clinics <u>must</u> be billed using the applicable fee code listed in the Diagnostic and Therapeutic Procedures Section of this Payment Schedule.	
57800	Percutaneous epidural injections	105.15
57801	Cervical epidural injection	add 88.92
57802	Intercostal nerve block(s) (maximum 2 units).....	95.41
57804	Paravertebral nerve block of thoracic and lumbar roots – each (maximum 4 units)	84.12
57806	Peripheral nerve block for chronic pain (maximum 2 units)	84.12
57808	Cranial nerve/branch block for chronic pain (maximum 2 units)	105.15
57810	Stellate ganglion block	105.15
57812	Intravenous sympathetic block by injection and infusion of Bretylium, Guanethidine and Reserpine	126.18
57814	Intravenous injection and infusion with lidocaine for the treatment of chronic pain	157.71
57816	Infiltration of tissues for the treatment of chronic pain (one or more sites, uni- or bilateral)	69.30
57818	Sacroiliac Joint Injections with Fluoroscopic Guidance – Unilateral	87.88
57820	– Bilateral	142.11
	Vertebral Facet Injection: Percutaneous Injection with Fluoroscopic Guidance	
57822	- First Site. (Max. of 1 units per patient per day and 6 units per patient per year.)	70.71
57824	- Each additional site. (Max. of 7 units per patient per day and 42 units per patient per year.)	37.20
	Percutaneous Denervation of sensory nerve(s) using Radiofrequency Ablation (RFA) or Rhizotomy	
57830	Single nerve	126.18
57832	Multiple nerves, same side	252.36
57834	Multiple nerves, different sides	358.29

Notes:

1) Fee codes 57830, 57832, and 57834 are restricted to Anaesthesiologists with Royal College certification in Pain Medicine.

2) Services billed using fee codes 57830, 57832, and 57834 must be performed with medical imaging guidance.

3) Fee codes 57830, 57832, and 57834 include services associated with medical imaging guidance, anaesthesia, sedation, and blocks (including fees associated with alcohol or other sclerosing solutions) if performed by the same physician.

IN-HOSPITAL DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
OTOLARYNGOLOGY		
57840	Laryngeal Videostroboscopy (procedure and interpretation)	108.50
PULMONARY FUNCTION STUDIES		
<p>The benefits for simple spirometry and standard lung mechanics represent the best of three recorded test results with or without bronchodilator.</p> <p>The benefit for standard lung mechanics includes simple spirometry.</p> <p>Vital capacity and flow volume loop <u>cannot</u> be claimed at the same time.</p>		
58000	Simple spirometry, e.g., vital capacity, without permanent record by transducer equipment FVC, FEV, MVV (MBC), etc.	7.85
Standard lung mechanics (with permanent record)		
58010	- Vital capacity, FEV, FEV/FVC	4.28
58015	- Repeat of 58010 after bronchodilator	1.73
58020	- 58010 plus MMEFR calculation	7.10
58025	- Repeat of 58020 after bronchodilator	2.76
58030	- MVV done together with 58010 or 5802084
58040	- Flow volume loop (FVC, FEV, FEV/FVC, V ₃₀ , V ₂₅)	10.75
58050	- Repeat of 58040 after bronchodilator	6.45
Complex Lung Mechanics'		
58100	- Functional residual capacity by gas dilution method	17.55
58110	- Functional residual capacity by body plethysmography	17.85
58120	- Airways resistance by plethysmography or estimated using esophageal catheter	16.05
58130	Lung Compliance (pressure volume curve of the lung from TLC to FRC)	48.15
58140	Carbon monoxide diffusing capacity by steady state of rest	11.25
58150	Carbon monoxide diffusing capacity by single breath method	18.00
Pulmonary Function Response to O ₂ and CO ₂		
58160	CO ₂ ventilatory response	14.60
58170	O ₂ ventilatory response (physician must be present)	21.80
Exercise Assessment – physician must be in attendance at all times		
58180	- Exercise diffusing capacity	16.03
58200	- Stage I: Graded exercise to maximum tolerance exercise (must include heart rate, Ventilation and ECG at rest and at each workload: ECG monitored at least 5 minutes post exercise	50.75
58210	- Same as 58200 plus 58010, 58020 or 58040 before and after exercise	60.10
58220	- Stage II: Repeated steady state graded exercise (must include heart rate, ventilation, VO ₂ , VCO ₂ , BP, ECG end tidal and mixed venous CO ₂ at rest, 3 levels of exercise and recovery)	65.40
58230	- Stage III: Same as 58220 plus arterial blood gases, PH and bicarbonate or lactate	88.26
58240	Exercise induced asthma assessment (workload sufficient to achieve a heart rate of 85% of max.; measurement of 58010, 58020 or 58040 before exercise and 5-10 minutes post exercise	24.50

IN-HOSPITAL DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
PULMONARY FUNCTION STUDIES (Cont'd)		
Gas Analysis		
58270	- Arterial puncture for blood gas analysis	10.20
58300	- A-a oxygen gradient (measurement of RQ by sampling mixed expired gas and using alveolar air equation)	16.79
58310	- Estimate of venous admixture (Qs/Qt) breathing pure oxygen	20.30
58320	- Mixed venous PCO ₂ by the rebreathing method	4.70
58330	- O ₂ saturation by oximeter (at rest and exercise)	10.80
58340	- Standard O ₂ consumption and CO ₂ production	6.45
58350	- Histamine or methylcholine threshold test	34.70
REMOTE MONITORING		
58500	Remote Obstructive Sleep Apnea (Rosa) stipend per patient per day	36.80
	- Fee codes 54170, 54171, 54132, 54134, 54166, and 54167 are payable with the ROSA stipend.	

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code Rate

GENERAL RADIOLOGY

Head and Neck

70100	Skull – routine (includes Towne’s views)	14.88
70101	Sella turcica	7.45
70110	Facial bones	11.92
70111	Nose	7.45
70112	Mandible	10.35
70113	Temporomandibular joints	11.92
70120	Sinuses	10.35
70121	Mastoids - acute	14.25
70122	- chronic	14.25
70130	Teeth - up to ¼ set	3.00
70131	- up to ½ set	6.70
70132	- full set	13.40
70133	- bitewing	4.46
70140	Eye, for foreign body	13.40
70141	- for localization (stereo-optics) additional	26.52
70142	Optic foramina	10.45
70150	Salivary gland region	8.94
70160	Neck for soft tissues	8.94
70170	Internal auditory canal	11.92
70190	Special additional view of any head and neck item	3.18

Spine and Pelvis

70200	Cervical spine	14.88
70210	Thoracic spine.....	14.88
70220	Lumbar or lumbosacral spine	14.88
70225	Sacrum and/or coccyx	7.45
70230	Pelvis - single view	8.94
70235	Pelvis and hips	11.92
70240	Sacroiliac joints	10.35
70245	Spine - scoliosis series	23.80
70250	Ribs - unilateral	8.94
70251	- for bilateral extra	7.85
70260	Sternum	8.94
70270	Special additional view of any spine and pelvis item	3.18

Extremities

70300	Clavicle	8.94
70301	Sternoclavicular joint	8.94
70303	Acromioclavicular joints – bilateral (with or without weighed distraction)	10.35
70310	Shoulder	8.94
70320	Scapula	8.94
70330	Humerus	8.94
70331	Elbow	8.94
70332	Ulna and radius	8.94
70333	Wrist	8.94
70334	Wrist and Hand	8.94
70335	Hand	13.05
70336	Finger	5.95
70337	Thumb, including metacarpals	7.45
70338	Scaphoid	8.94
70350	Hip	8.94
70351	Hip pinning, interpretation only	8.94

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
GENERAL RADIOLOGY (Cont'd)		
Extremities (Cont'd)		
70352	Femur	8.94
70353	Orthoroentgenogram	11.92
70360	Knee (including patella)	11.72
70364	Tibia and fibula	8.94
70366	Ankle	8.94
70368	Calcaneous	8.94
70370	Foot	8.94
70380	Toe	5.95
70390	Special additional view of any item in the section headed "extremities"	3.18
70395	Post reduction check	8.94
Skeletal Surveys		
Skeletal survey for bone age		
70430	- single film	7.45
70431	- 2 or more films or views	11.92
Other surveys		
70440	- basic for rheumatoid survey	3.30
70450	- basic for metabolic survey	3.30
70460	- basic for metastatic survey	3.30
70465	- plus per film or view for either of the above	3.30
Chest		
70501	Single film	6.40
70502	2 views	10.75
70503	3 or more views	12.45
70520	Mammography - unilateral	19.36
70521	- with tomosynthesis	add 15.81
70522	- bilateral	30.79
70523	- with tomosynthesis	add 31.62
70525	Screening mammography program	30.79
Note:		
Fee code 70525 should be claimed for screening mammograms performed as part of the screening program established by the Department of Health and Community Services. All other mammograms should continue to be billed as either fee code 70520 or 70522. Fee codes 70521 and 70523 cannot be added to screening mammograms or other diagnostic tests.		
Abdomen		
70600	Survey film (not to be billed in addition to 70601)	8.94
70601	Additional film studies (acute abdomen)	10.45
70610	Oesophagus	21.40
70620	Stomach and duodenum	38.15
70621	Stomach and duodenum with small intestinal series	58.40
70625	Small bowel only	25.53
70626	Upper GI - double contrast	46.40
70630	Colon - barium enema	29.40
70631	- with air study	49.80
70634	Defecography	28.00

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
GENERAL RADIOLOGY (Cont'd)		
Abdomen (Cont'd)		
70640	Cholecystogram	11.60
70645	T-Tube cholangiogram	23.80
70650	Operative cholangiogram, interpretation only	11.10
70651	Intravenous cholangio – tomography	17.89
70652	Intravenous cholangiogram	17.89
GU Tract		
70700	Survey film	8.94
70705	Retrograde pyelogram	11.92
70710	Intravenous pyelogram	25.42
70714	- with nephrotomogram	76.22
70721	Diuretic washout or infusion IVP	76.22
70724	- with nephrotomogram	35.72
70730	Urethrocystogram	8.94
70735	Stress urethrocystogram	22.67
70738	Voiding urethrocystogram	22.67
70741	Vasography	8.94
70745	Nephrostogram	29.55
Obstetrics and Gynaecology		
70800	Survey film	7.36
70810	Pelviometry	23.80
70814	Placentogram	9.80
70824	Hysterosalpingogram	14.88
70830	Intra-uterine foetal transfusion – radiological control	30.97

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code Rate

SPECIAL PROCEDURES

Arteriography – General

	Flush aortograph – includes aortic root, thoracic, lumbar and retrograde femoral	
71100	- procedure	125.17
71101	- interpretation	42.36
	Translumbar aortography	
71105	- procedure	119.98
71106	- interpretation	46.60
	Single selective arteriogram (renal, celiac, mesenteric, carotid, vertebral, splenic, subclavian, femoral and hepatic, etc.)	
71111	- procedure	217.44
71112	- interpretation	56.29
	Bilateral and multiple selective arteriograms	
71116	- procedure	391.37
71117	- interpretation	112.62
	Percutaneous femoral	
71120	- procedure	43.49
71121	- interpretation	56.29
	Percutaneous brachial	
71125	- procedure	43.50
71126	- interpretation	56.29
	Percutaneous angioplasty	
71130	- procedure	434.60
71131	- interpretation	56.29
71140	Embolization, e.g., for treatment of haemangioma or renal carcinoma (add to angiographic procedural fees)	108.26
71150	Percutaneous removal of intravascular foreign bodies	303.73
71160	Intra-arterial infusion of drugs, e.g., for control of gastrointestinal haemorrhage, charge appropriate angiographic procedural and radiological fees plus a per diem supervision fee of	29.55
71190	Percutaneous transhepatic catheter portal venography	311.05

Venous Studies

	Vena cavagram	
71200	- procedure	144.94
71201	- interpretation	56.29
71202	Percutaneous insertion of vena cava filter	459.12
	Selective venography (spinal, hepatic, axillary, lumbar, renal and thymic, etc.)	
71204	- procedure	217.44
71205	- interpretation	56.29
	Selective bilateral and multiple (e.g., renal vein studies)	
71210	- procedure	391.37
71211	- interpretation	46.60
	Single peripheral venogram (lower limb, orbital, etc.)	
71216	- procedure	36.00
71217	- interpretation	46.60
	Bilateral peripheral and pelvic	
71220	- procedure	59.98
71221	- interpretation	77.63
	Splenoportogram	
71225	- procedure	59.98
71226	- interpretation	31.05

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Rate
------	------

SPECIAL PROCEDURES (Cont'd)

Venous Studies (Cont'd)

	Lymphangiogram – single	
71230	- procedure.....	59.98
71231	- interpretation.....	31.05
	Lymphangiogram – bilateral	
71232	- procedure.....	119.98
71233	- interpretation.....	62.14

Cardiac Angiography

	All cardiac angiography except bilateral coronary studies	
71301	- interpretation.....	53.78
	Bilateral coronary angiography	
71306	- interpretation.....	110.34

Note:

These codes only apply when cardiac and/or bilateral coronary angiograms are referred to a Radiologist by a Cardiologist or Cardiac Surgeon for his/her written opinion.

Neuro Angiography

71390	Percutaneous embolization of spinal or cerebral AV malformations	437.30
71394	Carotid or vertebral artery occlusion by detachable balloon – percutaneous	297.30
	Percutaneous carotid angiogram – single (brachial)	
71400	- procedure.....	168.56
71401	- interpretation.....	56.29
	Percutaneous carotid angiogram – bilateral	
71402	- procedure.....	303.40
71403	- interpretation.....	93.78
	For repeat angiograms (oblique vies, stereo magnification, basil, etc.)	
71404	- procedure – single	202.26
71405	- interpretation – single	56.29
71406	- procedure – bilateral	364.09
71407	- interpretation – bilateral	93.78
	Myelogram (complete) prone	
71410	- procedure	89.90
71411	- interpretation	37.51
	Myelogram – supine (second puncture)	
71415	- procedure	37.19
	Posterior fossa myelogram	
71421	- procedure	37.19
	Discography	
71425	- procedure	55.79
71426	- interpretation	31.05
	Discography (each additional level)	
71427	- procedure	27.91
	Risagram	
71451	- interpretation	93.23

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
SPECIAL PROCEDURES (Cont'd)		
Gastro-Intestinal		
Sialogram		
71500	- procedure	23.99
71501	- interpretation	15.52
Insertion of nasogastric tube		
71504	- procedure	8.37
Ba. Swallow H-type fistula		
71508	- procedure	37.19
71509	- interpretation	IC
71510	Percutaneous gastrostomy	230.24
Hypotonic duodenography		
71514	- procedure	23.99
71515	- interpretation	IC
71518	Biliary duct calculus removal via T-Tube tract	116.20
71519	Percutaneous transhepatic biliary drainage including biliary stenting	386.24
Transhepatic cholangiogram		
71520	- procedure	72.46
71521	- interpretation	37.51
71522	Change of biliary drainage tube	144.94
71523	Injection of biliary drainage tube for reassessment	37.51
71524	ERCP - total procedure performed by a Radiologist	238.01
71525	- interpretation	10.62
Small bowel enema		
71528	- procedure	70.20
71529	- interpretation	15.52
Reduction of intussusception		
71534	- procedure and interpretation	44.25
71536	Oral or percutaneous placement of jejunostomy tube	70.20
Gastrografin enema		
71538	- procedure	37.18
71539	- interpretation	IC
Pneumoperitoneal and retroperitoneal air insufflation		
71541	- procedure	84.01
71542	- interpretation	46.60
Sinogram		
71549	- procedure	23.99
71550	- interpretation	15.52
Dacrocystogram		
71560	- procedure	23.99
71561	- interpretation	15.52
71570	Abscess management (intra-abdominal or deep organ) i.e. localization, placement of tube, drainage under fluoroscopy, ultrasound and/or CT	136.65
Respiratory System		
Laryngogram		
71600	- procedure	23.99
71601	- interpretation	31.23
Single bronchogram		
71612	- procedure	23.99
71613	- interpretation	31.23

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
SPECIAL PROCEDURES (Cont'd)		
Respiratory System (Cont'd)		
	Bilateral bronchogram	
71614	- procedure	36.00
71615	- interpretation	46.60
	Percutaneous lung biopsy	
71618	- procedure and interpretation	137.85
	Injection of air into the anterior mediastinum	
71624	- procedure	59.98
71625	- interpretation	15.52
	Injection of contrast into pleural cavity	
71626	- procedure	36.00
71627	- interpretation	15.52
Genito-Urinary		
	Hysterosalpingogram	
71700	- procedure (fluoroscopy) and interpretation	56.70
	Kidney film	
71710	- procedure (fluoroscopy)	15.52
71711	- interpretation	15.52
71714	Percutaneous antegrade insertion of ureteric stent	102.02
71715	Change of nephrostomy tube	144.94
	Cyst puncture (renal)	
71718	- procedure	121.95
	Injection of dye into cystic cavity	
71724	- procedure	36.00
71725	- interpretation	15.52
	Loopogram	
71728	- procedure	12.02
71729	- interpretation	12.02
	Catheterization	
71730	- procedure and interpretation	8.55
	Percutaneous nephrostomy	
71740	- performed by a Radiologist	175.70
Arthrogram, Tenogram, or Bursogram		
71800	- procedure	36.00
71801	- interpretation	34.09

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
OTHER ITEMS		
Other		
71840	Mammary ductography	29.35
71850	Intra-mammary needling for localization under mammographic control (procedure and interpretation)	
	- unilateral	70.35
Special Visit Premium		
71927	Daytime special visit (Monday to Friday)	33.12
71928	Evening (6:00 p.m. to midnight), Saturday, Sunday and Statutory Holidays	110.37
71929	Night (midnight to 8:00 a.m.)	165.56
Note:		
The above special visit premiums are payable in addition to the x-ray examination fees; however, only one premium per trip is payable regardless of the number of x-rays examined.		
IV Injections		
71941	Adult	15.00
71942	Cut-down	10.36
71948	Paediatric IV injection	10.36
71949	Scalp vein or cut-down	20.68
71950	Catheterization	10.36
71951	Injection – bursae, joints or tendon sheath	20.25
Tomography		
71960	1 plane	12.01
71961	2 planes	23.95
Fluoroscopy		
71980	Fluoroscopy alone, of any part	20.63
71985	Fluoroscopy control of a procedure done by another physician, per ¼ hour or part thereof (<u>IC</u> <u>required</u> indicating the name of the procedure, the physician who did the procedure and the amount of time involved.)	27.40

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code Rate

DIAGNOSTIC ULTRASOUND

Procedure codes indicated as IC must be billed IC indicating why the procedure had to be done by the Radiologist. See item 11.4 of the Preamble.

Notes:

1. A-mode – Implies a one-dimensional ultrasonic measurement procedure.
2. M-mode – Implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures.
3. Scan B-mode – Implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display.

Doppler Studies:

The Doppler fee codes listed in this section may be billed in combination with diagnostic ultrasound fee codes when a Doppler study is medically necessary and aids in the clinical decision making process. The written report must include a description of the findings when a Doppler fee code is billed. The use of Doppler for screening without a specific indication is not billable.

General

72050	Ultrasound control of a procedure, done by another physician, per ¼ hour or part thereof (<u>IC required</u> indicating the name of the procedure, the physician who did the procedure and the amount of time involved)	27.50
-------	--	-------

Head and Neck

Echoccephalography – midline, A-mode		
72100	- interpretation	12.09
72101	- procedure (IC)	23.22
Complete (midline and ventricular size)		
72104	- interpretation	18.18
72105	- procedure (IC)	23.22
Echography – ophthalmic		
Quantitative, A-mode		
72110	- interpretation	49.78
72111	- procedure (IC)	23.22
B-scan immersion		
72112	- interpretation	66.36
72113	- procedure (IC)	23.22
B-scan contact		
72114	- interpretation	33.20
72115	- procedure (IC)	23.22
Biometry (axial length – A-mode)		
72116	- interpretation	44.25
72117	- procedure (IC)	23.22
Foreign body localization		
72118	- interpretation	IC
72119	- procedure (IC)	23.22
Echography – neck (e.g., thyroid, neck mass or other pathology including A and/or B scans)		
72130	- interpretation	24.17
72131	- procedure (IC)	23.22
72132	- Doppler evaluation of neck pathology, one or more, uni- or bilateral..... add to 72130	16.33

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
DIAGNOSTIC ULTRASOUND (Cont'd)		
	Neonatal/paediatric cranial scan – complete	
72140	- interpretation	40.29
72141	- procedure (IC)	23.22
	Neonatal/paediatric spinal scan – complete	
72150	- interpretation	40.29
72151	- procedure (IC)	23.22
Heart/Major Blood Vessel		
	Echography, pericardial effusion, M-mode	
72200	- interpretation	26.84
72201	- procedure (IC)	23.22
	Ultrasound pericardiocentesis	
72210	- procedure and interpretation	50.51
	Echocardiography	
	Complete study - 1 dimension	
72220	- interpretation	45.06
72221	- procedure (IC)	17.92
	Complete study - 2 dimensions	
72222	- interpretation	83.64
72223	- procedure (IC)	21.08
	1 and 2 dimension study on same patient visit	
72224	- interpretation	92.13
72225	- procedure (IC)	26.00
	Limited study 1 or 2 dimensions for follow-up studies	
72226	- interpretation	20.71
72227	- procedure (IC)	15.46
	Doppler echocardiography	
72228	- interpretation	51.05
72229	- procedure (IC)	20.21
	Aorta only	
72230	- interpretation	57.61
72231	- procedure (IC)	23.22
	Vena cava only	
72232	- interpretation	57.61
72233	- procedure (IC)	23.22
Peripheral Vascular System		
	Extra-cranial vessel assessment above the aortic arch (bilateral, carotid and/or subclavian and/or vertebral arteries only)	
72240	- Doppler scan or B scan	25.32
72241	- frequency/ spectral analysis	25.32
72242	- frequency/ spectral analysis with Doppler scan	34.54
72243	- duplex scan, i.e. simultaneous real time, B-mode imaging and frequency/spectral analysis	62.22

Note:

Only one of fee codes 72240, 72241, 72242 and 72243 can be billed per patient per day.

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
DIAGNOSTIC ULTRASOUND (Cont'd)		
	Duplex Doppler assessment of hepatic and portal venous systems	
72244	- interpretation	16.33
72245	- procedure	19.72
Note: Fee code 72244 should only be billed in cases where hepatic and portal vessels are analyzed and should include a colour study of both systems and duplex study of at least one of the two systems.		
	Post-operative organ transplant arterial and/or venous Doppler assessment (assessment of the vascularity to the organ transplant rather than the ultrasound examination of the organ itself)	
72246	- interpretation	16.33
72247	- procedure	19.72
	Transcranial Doppler assessment	
72248	- interpretation	21.50
72249	- procedure	26.06
	Peripheral artery evaluation distal to inguinal ligament or axilla (<u>not</u> to be billed routinely with 72241, 72242 or 72243)	
72250	- Doppler scan or B-scan	20.95
72252	- frequency/spectral analysis with Doppler scan	28.79
72253	- duplex scan, i.e. simultaneous real time, B-mode imaging and frequency/spectral analysis	33.60
Notes: The following fee code combinations are not billable: 72250 with 72252 and 72253 with either of 72250 or 72252.		
	Venous evaluation – duplex scan i.e. simultaneous real time, B-mode imaging	
72254	- interpretation	20.40
72255	- procedure	31.43
	Duplex Doppler assessment of post-operative shunts	
72256	- interpretation	16.33
72257	- procedure	19.72
	Doppler assessment of one or more intra-abdominal and pelvic vessels, uni- or bilateral	
72258	- interpretation	25.76
72259	- procedure	22.36

Notes:

1. Doppler evaluation of intra-abdominal and pelvic vessels should not be performed routinely; it should be limited to investigation of problems where the result will influence management. Examples of acceptable uses for MCP billing purposes include:
 - a) placement of colour Doppler upon kidneys to assess for twinkle artifact if the presence of small stones is suspected;
 - b) assessment for ureteric jets if reduced or obstructed flow is suspected;
 - c) **evaluation of a solid lesion;**
 - d) **evaluation of a cyst with one or more walls or septations;**
 - e) evaluation of vessels where stenosis or occlusion is suspected;
2. The use of Doppler to distinguish the common bile duct from a vessel is not billable.
3. Fee code 72258 and 72259 are not to be billed for screening purposes; they should be billed for problem solving purposes.
4. A maximum of one unit of fee code 72258 is payable per patient session.
5. A maximum of one unit of fee code 72259 is payable per patient session.

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
DIAGNOSTIC ULTRASOUND (Cont'd)		
Thorax		
	Chest masses, pleural effusion – A and B-mode	
72340	- interpretation	40.29
72341	- procedure (IC)	23.22
	Ultrasonic thoracentesis	
72350	- procedure and interpretation	32.45
	Breast masses – scan B-mode (per breast)	
72360	- interpretation	36.04
72361	- procedure (IC)	33.96
72362	- Doppler evaluation of breast masses, one or more, uni- or bilateral add to 72360	16.33
Abdomen and Retroperitoneum		
	Abdominal scan, major (includes multiple organs and/or spaces)	
72400	- interpretation	57.11
72401	- procedure (IC)	60.83
	Abdominal scan, limited (e.g. single organ or follow-up study)	
72403	- interpretation	41.16
72404	- procedure (IC)	23.22
Scrotum/ Penis (includes Doppler examination)		
	Testicular (1 or both) or scrotal scanning	
72450	- interpretation	47.57
72451	- procedure (IC)	23.22
72452	Doppler evaluation of testicular flow when indicated, uni- or bilateral and/or evaluation of testicular/scrotal masses, one or more, uni- or bilateral add to 72450	16.33
Obstetrics, Gynaecology and Pelvis		
	Echography – Scan B-mode	
	Early pregnancy diagnosis	
72500	- interpretation	46.22
72501	- procedure (IC)	33.36
	Foetal age determination	
72510	- interpretation	28.43
72511	- procedure (IC)	21.44
	Placenta localization	
72520	- interpretation	28.43
72521	- procedure (IC)	22.36
	IUCD localization	
72530	- interpretation	28.43
72531	- procedure (IC)	22.36
	Pregnancy, complete	
72540	- interpretation	53.20
72541	- procedure (IC)	75.00
	Foetal assessment in – utero for physical condition of the fetus (requested by the specialist)	
72545	- interpretation and procedure	41.31
	Pelvic mass	
72570	- interpretation	46.21
72571	- procedure (IC)	22.36
	Endocavitary Scan	
72575	- interpretation	81.61
72576	- procedure	22.36
72578	Transvaginal sonohysterography, includes procedure, interpretation and introduction of saline or other intracavitary contrast media	123.65
	Ultrasonic amniocentesis	
72580	- interpretation and procedure	36.85

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
DIAGNOSTIC ULTRASOUND (Cont'd)		
	Doppler assessment of one or more fetal vessels including umbilical artery and vein	
72590	- interpretation	25.76
72591	- procedure	22.36
Extremities, including Doppler examination of soft tissue mass		
	Extremities, per limb (excluding vascular study)	
72610	- interpretation	17.37
72611	- procedure (IC)	23.22
	Scan of popliteal space	
72620	- interpretation	24.17
72621	- procedure (IC)	23.22
	Soft tissue mass, other than neck or limb (with or without Doppler examination)	
72630	- interpretation - single mass	17.37
72631	- interpretation - each additional mass (maximum of 2 units payable); add	12.08
72632	- procedure - per patient session, any number of masses (IC)	23.22
THERAPEUTIC ULTRASOUND		
72650	Occlusion of femoral or brachial pseudo-aneurysm under colour Doppler ultrasound guidance.....	136.55

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code **Rate**

COMPUTED TOMOGRAPHY

Head

73800	- without IV contrast	84.30
73801	- with IV contrast	89.50
73802	- with and without IV contrast	113.65

Complex Head

73805	- without IV contrast	84.25
73806	- with IV contrast	97.21
73807	- with and without IV contrast	111.02

Neck

73810	- without IV contrast	86.60
73811	- with IV contrast	97.50
73812	- with and without IV contrast	108.30

Thorax

73815	- without IV contrast	99.42
73816	- with IV contrast	99.68
73817	- with and without IV contrast	119.80

Cardio-thoracic

Cardio-thoracic CT is an imaging service of the cardio-thoracic structures including cardiac gating and 3D imaging post-processing, cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) and requires imaging without contrast material followed by contrast material(s).

73818	Cardio-thoracic	147.50
-------	-----------------------	--------

Notes:

1. The service described by 73818 includes the supervision of oral beta blockers and/or IV injection where clinically indicated.
2. Fee code 73818 is only eligible for payment when the service is performed using a minimum of a 64-detector CT scanner.
3. Fee code 73818 is only eligible for payment when a) one or more of the following indications are present: arterial and venous aneurysms; traumatic injuries of arteries and veins; arterial dissection and intramural haematoma; arterial thromboembolism; vascular congenital anomalies and variants; percutaneous and surgical, vascular interventions; vascular infection, vasculitis and collagen vascular disease; sequelae of ischemic coronary disease (i.e. myocardial scarring, ventricular aneurysms, thrombi); cardiac tumors and thrombi; pericardial diseases; cardiac function evaluation, especially in patients in whom cardiac function may not be assessed by magnetic resonance imaging or echocardiography OR b) a clinically stable symptomatic patient with low to intermediate probability of obstructive coronary disease; a clinically stable symptomatic patient who has planned surgery for valvular or structural heart disease; a patient has low to intermediate probability of stent stenosis where the stent has a diameter > 3mm; a patient with suspected clinically relevant congenital coronary artery anomalies.
4. Fee codes 73815, 73816 and 73817 are not eligible for payment with 73818.

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	5. Fee code 73818 includes all elements required to perform the study, including additional CT acquisition sequencing and/or post-processing, two or three dimensional reconstruction(s), and administration of contrast.	
	6. Fee code 73818 includes payment for a diagnosis of the entire detailed field of view including the lymph nodes, pleura, lungs, mediastinum, airways, bony thorax, spine and heart, veins, arteries and other related anatomical structure.	
	7. Fee code 73818 includes payment for a documented quantitative evaluation of coronary calcium for risk stratification when clinically appropriate.	
	8. CT coronary angiography is not insured:	
	a. for a patient with a high pre-test probability of obstructive coronary artery disease or ECG or cardiac enzyme evidence of an acute coronary syndrome	
	b. for purposes of screening, risk stratification or calcium scoring in asymptomatic patients.	
Abdomen		
73820	- without IV contrast	111.02
73821	- with IV contrast	124.83
73823	- with and without IV contrast	138.80
Extremities (1 or more)		
73825	- without IV contrast	94.73
73826	- with IV contrast	97.37
73827	- with and without IV contrast	97.21
Spine(s)		
73830	- without IV contrast	111.02
73831	- with IV contrast	124.83
73832	- with and without IV contrast	138.80
Pelvis		
73835	- without IV contrast	111.02
73836	- with IV contrast	124.83
73837	- with and without IV contrast	138.80
73838	CT Colonography	235.30

Notes:

1. Fee code 73838 includes all elements required to perform the study, including additional CT acquisition sequencing and/or post processing, two or three dimensional reconstruction(s), administration of contrast and faecal tagging, if rendered.
2. Fee codes 70631, 73820, 73821, 73823, 73835, 73836, 73837 are not eligible for payment with 73838.
3. CT colonography is an insured service only in the following circumstances:
 - a. individuals who are at moderate risk for colorectal cancer based on family history and the patient refuses colonoscopy or where the patient has been advised of the relative risks and benefits of CT colonography and colonoscopy and the patient refuses colonoscopy;

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code

Rate

-
- b. for surveillance examination in patients with a history of previous colonic neoplasm, where clinically appropriate;
 - c. when rendered for a patient for whom colonoscopy is technically infeasible, has been difficult in the past, or contraindicated;
 - d. for patients who are at increased risk for complications during endoscopy such as advanced age, sedation or anti-coagulation therapy, prior incomplete or difficult colonoscopy;
 - e. when double contrast barium enema services are unavailable or regarded as inadequate for clinical or diagnostic reasons.
4. Fee code 73838 includes payment for a diagnosis of the entire detailed field of view including colonic and extra-colonic structures.
 5. CT colonography also refers to and includes "virtual colonoscopy".

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
MAGNETIC RESONANCE IMAGING		
Head		
73850	- multislice SE (1 or 2 echos)	99.67
73851	- multislice IR	64.91
73852	- repeat (another plane, different pulse sequence – max. 2)	49.73
73853	- when gating is performed, (fee = <u>30%</u> of applicable imaging fee)	IC
Neck		
73855	- multislice SE (1 or 2 echos)	99.67
73856	- multislice IR	64.91
73857	- repeat (another plane, different pulse sequence – max. 2)	49.73
Thorax		
73860	- multislice SE (1 or 2 echos)	116.15
73861	- multislice IR	99.67
73862	- repeat (another plane, different pulse sequence – max. 2)	58.02
73863	- when gating is performed, (fee = <u>30%</u> of applicable imaging fee)	IC
Abdomen		
73865	- multislice SE (1 or 2 echos)	116.15
73866	- multislice IR	99.67
73867	- repeat (another plane, different pulse sequence – max. 2)	58.02
73868	- when gating is performed, (fee = <u>30%</u> of applicable imaging fee)	IC
Pelvis		
73870	- multislice SE (1 or 2 echos)	116.15
73871	- multislice IR	99.67
73872	- repeat (another plane, different pulse sequence - max. 2)	58.02
Extremity		
73875	- multislice SE (1 or 2 echos)	99.67
73876	- multislice IR	64.91
73877	- repeat (another plane, different pulse sequence – max. 2)	49.73
Spine		
Spinal segments recognized are cervical, thoracic, and lumbo-sacral		
Limited spine – 1 segment		
73880	- multislice SE (1 or 2 echoes)	116.15
73881	- multislice IR	99.67
73882	- repeat (another plane, different pulse sequence – max 2)	58.02
Intermediate spine – 2 adjoining segments		
73886	- multislice SE	135.37
73887	- multislice IR	153.05
73888	- repeat (another plane, different pulse sequence – max. 2)	67.62
Complex spine – 2 or more non-adjoining or complete segments		
73891	- multislice SE	201.24
73892	- multislice IR	153.05
73893	- repeat (another plane, different pulse sequence – max. 2)	100.18
73895	When gating of spine is performed, (fee = <u>30%</u> of applicable imaging fee)	IC

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code **Rate**

INTERVENTIONAL RADIOLOGY

74000	PET/CT One Region	507.88	
74001	PET/CT Two or More Regions	596.32	
74100	Endovascular obliteration of cerebral aneurysms by any technique	1,901.39	I.C.

Notes:

1. Includes all neurological exams done in association with the procedure, any diagnostic angiography performed at time of the procedure, fluoroscopy and any other necessary imaging performed at the time of the procedure;
2. Separate micro catheterization and stenting included if required;
3. Multiple aneurysms paid as follows: 2nd at 50%, 3rd at 25% (to a maximum of three aneurysms);
4. Radiological specialist assists are billable in Capacity "1" at 75% of the listed rate for code 74100 as per General Preamble;

74300	Percutaneous image guided radiofrequency ablation of solid tumor	575.00	
-------	--	--------	--

Notes:

1. Payable only for non-resectable liver, kidney, lung tumors, colorectal metastases and osteoid osteoma;
2. Payable to a maximum of 3 lesions treated at same session – 100% for first lesion, 50% for second and third lesion;
3. Includes all imaging guidance by any method necessary to complete the procedure.

DIAGNOSTIC BIOPSY

74520	Image-guided biopsy, any organ, by any radiographic technique	103.69	See biopsy codes
-------	---	--------	------------------------

NUCLEAR MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
<p>Fee code items which read "with computer data manipulation" may be claimed in <u>addition</u> to preceding fee code item(s) if quantification or data manipulation is carried out in addition to visual inspection of imaging studies. Such activity must add significant diagnostic information not available by inspection alone and does not include simple image enhancement techniques such as smoothing, background subtraction, etc. Recording of images on video tape for replay and production of images on the video display of a computer <u>do not</u> in themselves justify claims for "computer data manipulation."</p>		
Cardiovascular System		
75000	Venography – peripheral and superior vena cava	41.28
75001	- with computer data manipulation add	12.22
75002	First transit without blood pool images	16.31
75003	First transit with blood pool images	32.60
75004	- when done in conjunction with an organ scan	19.08
75005	- with computer data manipulation add	9.78
75006	Cardioangiography – first pass for shunt detection, cardiac output and transit studies	58.62
Myocardial perfusion scintigraphy		
75007	- immediate post stress	68.18
75008	- post rest	61.42
75010	Myocardial scintigraphy – acute infarction injury	41.28
75011	Myocardial wall motion studies	57.30
75012	- repeat same day (max. of 3 repeats)	28.69
75013	Myocardial wall motion studies with ejection fraction	96.35
75014	- repeat same day (max. of 3 repeats)	43.98
75015	- with computer data manipulation add	27.92
75016	Detection of venous thrombosis with radioiodinated fibrogen – up to 10 days	43.98
75018	Intravenous Dipyridamole Stress test - includes monitoring time spent with the patient by the Nuclear Medicine Physician (EKG interpretation payable in addition)	29.63
Endocrine System		
75020	Adrenal scintigraphy with iodocholesterol	66.15
75021	- with iodocholesterol and dexamethasone suppression	66.15
75022	- with MIBG	62.90
Thyroid uptake		
75023	- initial	26.90
75024	- repeat	10.63
Thyroid scintigraphy		
75025	- with TC99m or I-131	42.98
75026	- with I-123	43.60
Parathyroid scintigraphy		
75027	- dual isotope technique with T1201 and TC99m iodine	78.63
75028	- with computer data manipulation add	25.73
75029	Metastatic survey with I-131	72.08
Gastrointestinal System		
75034	C15 breath test for <i>Helicobacter pylori</i>	24.95
Schilling test		
75035	- single isotope	17.96
75036	- dual isotope	16.01
Malabsorption test		
75037	- with C14 substrate	17.96
75038	- with whole body counting	22.54

NUCLEAR MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Gastrointestinal System (Cont'd)		
75039	Gastrointestinal protein loss	26.88
75040	Gastrointestinal blood loss Cr51	12.04
75041	Calcium absorption – Ca45	12.04
75042	Calcium47 absorption/excretion	43.98
75043	Esophageal motility studies – 1 or more	123.30
75044	Gastrointestinal transit	59.79
75045	Gastroesophageal reflux	49.60
75046	Gastroesophageal aspiration	59.59
	Abdominal scintigraphy for gastrointestinal bleed	
75047	- TC99m sulphur colloid or TC04	59.59
75048	- labelled RBCs	65.08
75049	- LeVeen shunt potency	43.98
75050	Biliary scintigraphy	74.82
75051	Liver/spleen scintigraphy	59.59
75053	Salivary gland scintigraphy	54.67
75054	With computer data manipulation add	17.15
Genitourinary System		
75060	Dynamic renal imaging	78.63
75061	Computer renal function (includes first transit)	78.63
75062	- repeat after pharmacological intervention	26.31
75063	Static renal scintigraphy	59.70
75064	ERPF by blood sample method	10.63
75065	GFR by four blood sample method	94.18
Note:		
GFR by fewer than four blood samples is not payable. GFR by more than four samples is payable at the listed rate.		
75066	Cystography for vesicoureteric reflux	32.60
75067	Testicular and scrotal scintigraphy (includes first transit)	55.93
75068	With computer data manipulation add	25.73
Hematopoietic System		
75069	Plasma volume	8.99
75070	Red cell volume	8.99
75071	Ferrokinesics – clearance, turnover and utilization	42.08
75072	Red cell, white cell or platelet survival	26.02
75073	Red cell survival with serial surface counts	35.95
75074	Bone marrow scintigraphy	75.65
75075	Single site	47.88
75076	In-111 leukocyte scintigraphy - whole body	80.95
75077	- single site	58.06
75078	Indium-CL scintigraphy	47.88
75079	With computer data manipulation add	13.43

NUCLEAR MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Musculoskeletal System		
75080	Bone scintigraphy - general survey	71.32
75081	- single site	47.00
75082	Gallium scintigraphy - general survey	79.13
75083	- single site	56.39
75084	Bone mineral density, by single photon method	10.63
75085	Total bone calcium – neutron activation	75.18
75086	Bone mineral content by dual photon absorptiometry - single site	43.45
75087	- 2 or more sites	59.01
75088	With computer data manipulation	add 16.21
Nervous System		
CSF circulation		
75090	- with TC99 m or I-131 HSA	54.42
75091	- with Indium-111	67.66
75092	- via shunt puncture	72.08
75093	Brain scintigraphy	54.67
75094	- cerebral blood flow study	add 57.58
75095	- with computer data manipulation	add 14.66
75096	HMPAO regional brain perfusion with SPECT	79.45
Respiratory System		
75100	Perfusion lung scintigraphy	50.07
75101	Ventilation lung scintigraphy	46.66
75102	Perfusion and ventilation scintigraphy – same day	108.69
75103	With computer data manipulation	add 11.79
Miscellaneous		
75200	Radionuclide lymphangiogram	74.32
75201	Ocular tumour localization	77.25
75202	Tear duct scintigraphy	55.95
75203	Total body counting	62.67
75205	Other scan (approved but not currently listed)	60.03
75206	With computer data manipulation	add 10.99
SPECT		
75210	SPECT – Single Photon Emission Computerized Tomography	36.85
75212	SPECT – with transmission attenuation correction	53.01
Notes:		
1. SPECT <u>includes</u> quantification and data manipulation.		
2. The specific organ or system imaged can be claimed using the applicable fee code in addition to 75210 or 75212.		
3. Only one of 75210 and 75212 can be claimed for SPECT imaging.		
Special Visit Premiums		
75227	Daytime special visit (Monday to Friday)	34.41
75228	Evening (6 p.m. to midnight), Saturdays, Sundays, and Statutory Holidays	123.08
75229	Night (midnight to 8 a.m.)	169.37

Note: The above special visit premiums are payable in addition to nuclear medicine fees, however, only one premium per trip is payable regardless of the number of services provided.

NUCLEAR MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
Therapy using Radioisotopes		
The rate listed <u>includes</u> treatment planning, dosage calculation and preparation of materials.		
Appropriate visit and procedural benefits (e.g., paracentesis) may be claimed in addition.		
Thyroid benefits (75250, 75251 and 75252) include administration(s) within any 3 month period.		
75250	Thyroid malignancy	102.70
75251	Hyperthyroidism	93.35
75252	Induction of hypothyroidism	79.81
75255	Prostate malignancy	79.81
75256	Polycythaemia	45.57
75257	Metastatic disease of bone	84.95
75260	Ascites and/or pleural effusion(s) due to malignancy	56.86
75261	Arthritis – single or multiple site	37.51
75262	Metastatic disease with radioactive lymphogram	56.86

OBSTETRICS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
OBSTETRICAL CARE				
80002	Multiple births – each child extra		154.84	
80004	Delivery		519.65	
80006	Vaginal birth following a Caesarean Section add		53.14	
80010	Post-natal care in hospital		57.47	
80012	Post-natal care in office		36.16	
80014	Attendance at labour by Family Physician		423.10	
80016	Attendance at delivery by Obstetrician		220.07	
High risk pregnancies				
80018	Fetal Doppler arterial flow frequency analysis (IOP)		23.97	
80020	Fetoscopy (may include fetal blood sample, cell harvest or amniocentesis) (IOP)		165.40	
80024	Double set up examination to rule out placenta previa – patient subsequently allowed to labour (same physician)		58.0	
80026	Double set up – trial of forceps – failed leading to Caesarean Section (same physician)		60.44	
80028	Chorionic villus sampling (IOP)		153.00	
80030	Application of scalp electrode in high risk pregnancy		23.86	
80032	Insertion of intrauterine catheter		22.90	
80034	Foetal scalp blood sampling		40.80	

OBSTETRICS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Assist	FP/ Spec.	Anaes.
ANAESTHESIOLOGY			
80040			5
80042			5
80044			1
<p>If the patient has an operative delivery, a maximum of 12 one-quarter hour units for epidural prior to delivery, plus the units of time for the delivery, plus, if necessary, another maximum of 12 one-quarter hour epidural units post-delivery, are payable for management of pain. (Claim IC when total epidural/anaesthetic time units in the above combination exceed 12).</p>			
80046			4 units + time

Anaesthesiology Notes re delivery following epidural:

1. The subsequent operative delivery or delivery by Caesarean Section is considered to constitute a separate anaesthetic procedure.
2. Time units for the subsequent delivery will be considered as additional to the total number of quarter-hour units of epidural anaesthetic and payable at double the time unit rate when in excess of 2 hours anaesthetic time.

OBSTETRICS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
OPERATIVE DELIVERY, excluding low or outlet forceps delivery				
81002	- Caesarean Section with or without sterilization, procedure and post-operative care only	55.54	618.30	6
81004	- Caesarean Section, plus hysterectomy	55.54	872.41	8
81006	- Operative delivery – other than Caesarean Section	55.54	558.10	5

OBSTETRICS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SURGICAL OBSTETRICS				
Induction				
Notes:				
	1. Only the <u>first</u> induction may be claimed per patient per pregnancy, regardless of the number of attempts at induction or the number of physicians involved.			
	2. Induction is <u>only</u> payable when the physicians who bill for induction and delivery (other than Caesarean Section) are in different specialties.			
	3. Induction <u>cannot</u> be claimed by the physician who bills for delivery (other than Caesarean Section).			
81010	Surgical induction of labour		28.07	3
81012	Medical induction of labour (oxytocin infusion)		63.09	
Abortion				
	- complete – under 20 weeks		VF	
81014	- D&C for incomplete abortion (IOP)		135.26	4
81016	- surgical		195.36	4
81018	Amniocentesis (IOP)		106.28	
81020	Hysterotomy – abdominal or vaginal with or without sterilization	55.54	194.10	6
81022	Missed abortion, with or without intra-uterine hypertonic solution		166.63	4
81023	Insertion of laminaria device		6.04	
Note:				
Fee code 81023 can be billed in addition to fee codes 81016 or 81022 when a laminaria device is used to dilate the cervix prior to these procedures. It cannot be billed in addition to any other fee code or for medical induction of labour.				
81024	Repair of third degree laceration		72.53	4
81026	Repair of vaginal laceration and/or large haematoma		49.13	4
81028	Retained placenta removal		49.13	4
Fee codes 81024, 81026 and 81028 are <u>not</u> payable to the same physician in addition to the delivery fee.				
81030	Ectopic pregnancy	55.54	353.53	6
81032	Suture of incompetent cervix during pregnancy		151.19	4
81034	Emergency removal of sutures (except at delivery)			4
81036	Sterilization – postpartum (same physician), in addition to delivery and postpartum fee	55.54	114.50	6
81038	Uterine inversion, manual replacements		131.03	4

ANAESTHESIA FOR SURGICAL DENTAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
<p>For rules applicable to billing for Anaesthesiologists' services including premiums, please refer to the Anaesthesiology Services Section of the Preamble</p>		
EXTRACTIONS		
84040	Removal of erupted tooth, uncomplicated procedure	4
84044	Surgical removal of erupted tooth, requires elevation of mucoperiosteal flap, and removal of bone and/or sectioning of tooth	4
84046	Removal of residual roots - covered by soft tissue	4
84050	- covered by bone	4
EXTRACTION OF IMPACTED TEETH		
84060	Impaction, requires incision of overlying soft tissue and removal of tooth	4
84062	Impaction, requires incision of overlying soft tissue, elevation of flap, and either removal of bone or sectioning and removal of tooth	4
84064	Impaction, requires incision of overlying soft tissue, elevation of flap and removal of completely bone covered tooth	4
84066	Impaction, requires incision of overlying soft tissue, elevation of flap, removal of bone and/or sectioning of tooth for removal and/or presents unusual circumstances or difficulties	4
SURGICAL EXPOSURE OF TEETH		
Surgical exposure		
84070	- uncomplicated, soft tissue coverage	4
84072	- complex, hard tissue coverage	4
84074	- unerupted tooth with orthodontic attachment	4
SURGICAL MOVEMENT OF TEETH		
84080	Repositioning, surgical	4
84082	Transplantation - erupted tooth	4
84084	- unerupted tooth	4
REMODELLING AND RECONTOURING ORAL TISSUES		
84100	Alveoloplasty - in conjunction with extractions	4
84102	- not in conjunction with extractions	4
Remodelling of Bone		
84104	Mylohyoid ridge, remodelling	4
84106	Genial tubercles, remodelling	4
Excision of Bone		
84108	Nasal bone	4
84110	Torus palatinus	4
84112	Torus mandibularis	4
84114	Removal of Bone, Exostosis, Multiple	4
84116	Reduction of Bone, Tuberosity	4

ANAESTHESIA FOR SURGICAL DENTAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
REMODELLING AND RECONTOURING ORAL TISSUES (Cont'd)		
Gingivoplasty and/or Stomatoplasty		
84120	Gingivoplasty	4
84122	Gingivectomy	4
84124	Excision of vestibular hyperplastic tissue	4
84126	Surgical shaving of papillary hyperplasia of the palate	4
84128	Excision of pericoronal gingiva (for retained tooth/implant)	4
Remodelling Floor of Mouth		
84130	Full arch lowering of the floor of the mouth	10
Vestibuloplasty		
84132	Submucosal, uncomplicated	4
84134	Secondary epithelialization, uncomplicated	4
84136	Vestibuloplasty - with labial inverted flap (secondary epithelialization, complicated)	5
84138	- with skin graft	5
84140	- with mucosal graft	5
Alveolar Ridge Reconstruction		
84142	Alveolar ridge reconstruction, with autogenous bone/arch	10
84144	Ceramic grafting	4
TESTS, HISTOLOGICAL		
84150	Biopsy - soft oral tissue, by incision	4
84152	- hard oral tissue, by incision	4
SURGICAL EXCISIONS		
Surgical Excision, Tumours, Benign		
84160	Tumours, benign, scar tissue, inflammatory or congenital lesions of soft tissue - less than 2 cm.	4
84162	- over 2 cm.	4
84164	Tumours, benign, bone tissue - less than 2 cm.	4
84166	- over 2 cm.	5
84168	Extra-large lesions over 3 cm. or complicated	5
Surgical Excisions, Tumours, Malignant		
84170	Tumours, malignant, soft tissue - less than 2 cm.	4
84172	- over 2 cm.	4
84174	Tumours, malignant, bone tissue - less than 3 cm.	5
84176	- 3 to 6 cm.	5
84178	Large Lesions over 6 cm. or complicated	10
Cheiloplasty (lip shave)		
84180	Cheiloplasty - partial	4
84182	- total	4
84190	Grafts, bone, to the jaw	10

ANAESTHESIA FOR SURGICAL DENTAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
SURGICAL EXCISIONS (Cont'd)		
Augmentations, Prosthetic, of the Jaw		
84200	Implantation of intraosseous prosthesis (continuity defect)	10
84202	Removal of intraosseous prosthesis	4
84204	Augmentation of the chin	4
Surgical Excision of Cysts/Granulomas		
84210	Less than 2 cm.	4
84212	Over 2 cm.	4
84214	Cyst, complicated (over 6 cm.)	5
84216	Marsupialization	4
SURGICAL INCISIONS		
Surgical Incision and Drainage and/or Exploration, Intraoral		
84220	Intraoral surgical exploration, soft tissue	4
84222	Intraoral abscess - soft tissue	4
84224	- in major anatomical area with drain	5
Surgical Incision and Drainage and/or Exploration, Extraoral		
84230	Extraoral abscess - superficial, soft tissue	4
84232	- deep, soft tissue, with drain	5
Surgical Incision for Removal of Foreign Bodies		
84240	From skin or subcutaneous alveolar tissue	4
84242	Of reaction-producing foreign bodies	4
84244	Of needle from musculoskeletal system	4
Sequestrectomy (for Osteomyelitis)		
84250	Sequestrectomy - for osteomyelitis	7
84252	- and saucerization	7
84254	Extraoral sequestrectomy (complicated)	7
Mandibulectomy		
84260	- partial (3-6 cm.)	4
84262	- hemi (6-12 cm.)	5
84264	- total (more than 12 cm.)	7
Maxillectomy		
84270	- partial (3-6 cm.)	4
84272	- hemi (6-12 cm.)	5
84274	- total (more than 12 cm.)	7
Apicoectomy		
84280	Apicoectomy and/or apical curettage - 1 root	4
84282	- 2 roots	4
84284	- 3 roots or more	4

ANAESTHESIA FOR SURGICAL DENTAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
TREATMENT OF FRACTURES		
84300	Intermaxillary fixation	5
84302	Intramaxillary suspension (wiring)	5
84304	Circumzygomatic wiring	5
84306	Removal of wire, plate and screw	5
84308	Removal of intermaxillary fixation	5
84310	Occlusal equilibration	5
Fractures, Reduction, Mandible		
84330	- closed (simple)	5
84332	- open (simple)	5
84334	- open (multiple)	5
Fractures, Reduction, Maxilla		
Horizontal, LeFort I		
84340	- closed (simple)	5
84342	- open (simple)	6
84344	- open (multiple)	6
84346	Compound fracture of maxilla (requiring reduction and soft tissue repair)	8
Pyramidal, LeFort II		
84350	- closed (simple)	5
84352	- open (unilateral)	8
84354	- open (bilateral)	8
Fractures, Reduction, Naso-orbital		
84360	- closed (simple)	5
84362	- open (single)	5
84364	- open (multiple)	6
Fractures, Reduction, Malar Bone		
84370	- closed (simple)	5
84372	- open (simple)	5
84374	- open, complicated, orbit involved	6
Fractures, Reduction, Zygomatic Arch		
84380	- closed	5
84382	- open	5
Fractures, Reduction, Craniofacial Dysfunction, LeFort III Transverse		
84390	- closed	5
84392	- open	10
Fractures, Reduction, Alveolar		
84400	Fracture, alveolar, debride, teeth removed - no fixation	4
84402	Reduction, alveolar - closed, with teeth	4
84404	- open, with teeth	4
84406	Replantation, avulsed tooth	4
84410	Repositioning of traumatically displaced teeth	4
84412	Repairs, lacerations - uncomplicated, 5 cm. or less	4
84414	- complicated, up to 5 cm.	4
84416	- complicated, over 5 cm.	4

ANAESTHESIA FOR SURGICAL DENTAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
TREATMENT OF MAXILLOFACIAL DEFORMITIES		
Osteotomy, Ostectomy, Ramus of Mandible		
84426	Osteotomy - unilateral	8
84428	- subcondylar, closed	10
84430	- subcondylar, open	10
84432	- ramus, oblique, extraoral	10
84434	- ramus, oblique, intraoral	10
84436	Osteotomy/ostectomy body of mandible	10
84438	Osteotomy - coronoidectomy	5
84440	- condylar neck	10
84442	- sagittal split	10
Osteotomy, Miscellaneous		
84444	- oblique with bone graft	10
84446	- inverted "L"	10
84448	- "C"	10
Osteotomy, Maxilla		
84450	Osteotomy - maxilla, LeFort I	20
84452	- maxilla, LeFort II	20
84454	- maxilla, LeFort III	20
84464	Closure or cleft fistula - alveolar	4
84466	- palatal	6
84468	Pharyngoplasty	8
84470	Submucous resection	4
Osteotomy, Maxilla/Mandible, Segmental		
Maxilla		
84480	Osteotomy, segmental - anterior	10
84482	- posterior	10
84484	Osteotomy, midpalate split - anterior	10
84486	- complete	10
Mandible		
84488	Osteotomy, segmental - anterior with transfer of mental eminence	10
84490	- anterior without transfer of mental eminence	10
84492	- posterior	10
84494	Osteotomy, lower border, mandible	10
84496	Osteotomy, total dento-alveolar	10
Osteotomy, with "Interpositional Graft"		
84500	- using bone	10
84502	- using alloplast	10
84504	- using cartilage	10
Genioplasty		
84510	Genioplasty - sliding	10
84512	- reduction	10
84514	- augmentation with graft	10
84516	Myotomy, suprahyoid	10

ANAESTHESIA FOR SURGICAL DENTAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
TREATMENT OF MAXILLOFACIAL DEFORMITIES (Cont'd)		
Miscellaneous Treatment of Maxillofacial Deformities		
84520	Corticotomy, per 9 cuts	10
84522	Interdental septotomy	4
84524	Surgical expansion of the palate	8
Palatorraphy		
84530	Palatorraphy - anterior (closure of palatine fissure)	8
84532	- posterior	8
84534	- total	8
84536	- with bone graft separate	8
84538	- with bone graft to anterior alveolar ridge separate	8
Frenectomy		
84540	Frenectomy	4
84542	Frenoplasty	4
Glossectomy		
84550	Glossectomy - partial, anterior wedge	8
84552	- full postero-anterior wedge	8
Cleft Surgery		
84560	Primary unilateral cleft lip repair	8
84562	Secondary unilateral cleft lip repair	8
84564	Primary bilateral cleft lip repair	8
84566	Secondary bilateral cleft lip repair	8
84568	Reconstruction of cleft lip with lip switch flap	8
84570	Complex reconstruction or revision of cleft lip	8
84572	Closure of alveolar cleft	8
Oronasal Fistula		
84580	Primary closure at time of initial surgery	4
84582	Secondary closure - with palatal flap	4
84584	- with pharyngeal flap	4
84586	- with tongue flap	4
84588	- with buccal flap	4
TREATMENT OF TEMPOROMANDIBULAR JOINT DYSFUNCTIONS		
TMJ, Dislocation, Management		
84600	TMJ, dislocation - open reduction (exposure of joint)	5
84602	- closed reduction, uncomplicated	4
84604	- closed reduction under general anaesthetic	4
84608	TMJ, luxation reduction, under general anaesthetic	4
84610	TMJ, manipulation under general anaesthesia	4
84612	TMJ, fixation (arch bars)	5
TMJ, Capsule, Management of		
84616	Meniscectomy	5
84618	Capsulorrhaphy	5
84620	Myotomy, lateral pterygoid muscle	5
84622	Plication, posterior attachment of the disk of the TMJ, in cases of internal derangement	5

ANAESTHESIA FOR SURGICAL DENTAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
TREATMENT OF TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (Cont'd)		
TMJ, Condylar, Surgical		
84626	Condylectomy	5
84628	Condylotomy	5
84630	Osteotomy, oblique, with silastic interposition for ankylosis (graft)	10
TMJ, Articular Eminence, management of		
84634	Reconstruction of the glenoid fossa, zygomatic arch and temporal bone (Obwegeser technique)	5
84636	Articular eminence, arthroplasty	5
TMJ, Arthrocentesis		
84640	Puncture and aspiration	4
TMJ, Management by Injection		
84644	Anti-inflammatory drugs	4
84646	With sclerosing agent	4
TMJ Appliance Splints (for use ONLY in post-surgical cases)		
84650	Maxillary	5
84652	Mandibular	5
84654	Occlusal adjustment	5
TREATMENT OF SALIVARY GLANDS		
84670	Salivary duct - dilation	4
84672	- insertion of polyethylene tube	4
84674	- sialodochoplasty	4
84676	- reconstruction	4
84678	- sialolithotomy anterior 1/3 of canal	4
84680	- sialolithotomy posterior 2/3 of canal	4
84682	- external approach	4
84684	Excision - submandibular gland	4
84686	Excision - sublingual gland	4
84688	Excision - mucocele	4
84690	Excision - ranula	4
84692	Marsupialization of ranula	4
84694	Salivary gland removal, parotid	4
NEUROLOGICAL DISTURBANCES		
Trigeminal Nerve		
84700	Injection for destruction	4
84702	Avulsion at periphery	4
84704	Alcoholization of a branch	4
84706	Infiltration of a branch for diagnosis	4
Inferior Dental Nerve		
84716	Complete avulsion	4

ANAESTHESIA FOR SURGICAL DENTAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
NEUROLOGICAL DISTURBANCES (Cont'd)		
Surgery		
84720	Injured nerve repair - primary	IC
84722	- secondary	IC
84724	Neural transposition and decompression	IC
84726	Implantation of electrode for peripheral nerve stimulation	IC
84728	Excision of tumour or neuroma	4
84732	Nerve repair with graft	IC
ANTRAL SURGERY		
Recovering Foreign Bodies		
84740	Immediate recovery of dental root or foreign body from the antrum	4
84742	Immediate closure of antrum by another dental surgeon	4
84744	Delayed recovery of a dental root with oral antrostomy	4
84746	Antral surgery with nasal antrostomy	4
Oro-antral Fistula Closure (same session)		
84758	Closure - with buccal flap	4
84760	- with gold plate	4
84762	- with palatal flap	4
Oro-antral Fistula Closure (subsequent session)		
84766	Closure - with buccal flap	4
84768	- with gold plate	4
84770	- with palatal flap	4
HAEMORRHAGE CONTROL		
84780	Secondary haemorrhage control	4
84782	Haemorrhage control - using compression and haemostatic agent	4
84784	- using haemostatic substances and sutures (includes removal of bony tissues if necessary)	4
GRAFTS, SURGICAL		
Harvesting of Intraoral Tissue for Grafting to Operative Site		
84800	Bone	4
84802	Cartilage	4
Harvesting of Extraoral Tissue for Grafting to Operative Site (to include illium, rib, etc.)		
84820	Bone	4
84822	Cartilage	4
EMERGENCY PROCEDURES		
84850	Tracheotomy	5
84852	Crico- thyroidotomy	5

ANAESTHESIA FOR SURGICAL DENTAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
SPECIAL PROCEDURES		
84920	Anaesthetic standby at the request of the attending physician	3
84922	Monitoring under IV sedation	4
84926	Anaesthetic additional fee for adults 70 or older add	1
84930	For patients undergoing anaesthesia in the prone or sitting position	1
84934	Controlled hypotensionadd	10

SURGICAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

SURGICAL PREMIUMS

Special Visit Premiums

Please see Visit Premiums, 18.2 of the Preamble. Anaesthesiologists, please note that visit premium fees do not apply to maintenance procedural fee codes.

After Hours Surgical Procedure Premiums

Surgical procedures that are non-elective, unscheduled and which either require the services of an Anaesthesiologist, or are performed using one of the regional nerve blocks specified in fee code 54150 for local anaesthetic purposes, qualify for premiums when commenced between 6:00 p.m. and 7:00 a.m. or on Saturdays, Sundays or Statutory Holidays.

Vaginal deliveries, Caesarean sections and other operative deliveries qualify for premiums when commenced between 6:00 p.m. and 7:00 a.m. or on Saturdays, Sundays or Statutory Holidays.

Prem Code		Assist	FP/ Spec.	Anaes.
01	Procedures that qualify and commence between 6:00 p.m. and midnight or on Saturdays, Sundays or Statutory Holidays add	30%	30%	
02	Procedures that qualify and commence between 6:00 p.m. and midnight or on Saturdays, Sundays or Statutory Holidays (Anaesthesiologists only) add			46%
03	Procedures that qualify and commence any night between midnight and 7:00 a.m. add	50%	50%	50%

SURGICAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Morbidly Obese Patients

Premium code 04 is eligible for payment once per patient per physician in addition to the amount eligible for payment for specific, approved major surgical procedure(s) listed below where a morbidly obese patient undergoes major surgery to the neck, hip, peritoneal cavity, pelvis or retroperitoneum and:

- a. the patient has a Body Mass Index (BMI) greater than 40 for major surgery on the peritoneal cavity, pelvis, retroperitoneum and hip or a BMI greater than or equal to 45 for major surgery on the neck;
- b. the surgery is rendered in hospital under general anaesthesia using either an open technique for the neck and hip, or an open or laparoscopic technique for the peritoneal cavity, pelvis, retroperitoneum; and
- c. the principal surgical technique is neither aspiration, core or fine needle biopsy, dilation, endoscopy, mediastinoscopy, thoracoscopy, cautery, ablation nor catheterization.

Prem Code		Assist	FP/ Spec.	Anaes.
04	Approved procedures on morbidly obese patients	add	10%	10%

Note:

Premium code 04 is only payable with the following fee codes:

Obstetrics

81002 81004 81030

Operations on the Musculoskeletal System

92740	92764	92774	92888	92988	93024
92742	92766	92776	92910	92996	93026
92754	92768	92778	92920	92998	93030
92760	92770	92882	92932	93000	93032
92762	92772	92884	92944	93022	93046

Operations on the Respiratory System

94460	94466	94482	94532	94542
94462	94468	94484	94536	94550
94464	94480	94530	94540	

SURGICAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Operations on the Cardiovascular System

95136	95152	95164	95176	95188	95296
95138	95154	95166	95178	95190	95306
95142	95156	95168	95180	95192	95320
95144	95158	95170	95182	95222	95326
95146	95160	95172	95184	95258	
95150	95162	95174	95186	95260	

Operations on the Haemic and Lymphatic System

95370	95413	95415	95438		
-------	-------	-------	-------	--	--

Operations on the Digestive System

95870	96060	96164	96442	96570	96660
95872	96062	96170	96444	96572	96662
95874	96064	96174	96448	96574	96672
95876	96066	96176	96450	96576	96676
95878	96068	96178	96452	96578	96678
95900	96074	96200	96454	96582	96702
95906	96076	96204	96460	96584	96720
95916	96078	96206	96470	96586	96732
95918	96080	96208	96508	96590	96734
95920	96092	96220	96514	96594	96748
95922	96096	96230	96516	96596	96750
95932	96098	96260	96518	96598	96752
95934	96100	96262	96520	96620	96754
95936	96102	96268	96524	96622	96760
95950	96106	96270	96530	96626	96762
95952	96108	96272	96532	96634	96770
95956	96112	96278	96534	96636	96772
95962	93130	96304	96536	96642	96780
95964	96132	96314	96542	96644	
95966	96134	96316	96550	96646	
95980	96136	96434	96560	96648	
95982	96154	96436	96562	96650	
95984	96162	96438	96564	96652	

SURGICAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Operations on the Urogenital System

96820	96865	96972	97018	97142	97234
96822	96868	96974	97020	97144	97236
96824	96872	96976	97024	97150	97238
96826	96874	96978	97026	97152	97240
96828	96876	96980	97028	97154	97260
96832	96880	96982	97030	97156	97262
96836	96884	96990	97040	97160	97264
96838	96886	96992	97042	97162	97266
96840	96888	97000	97044	97164	97330
96842	96910	97002	97046	97166	97332
96844	96912	97004	97130	97168	97334
96850	96940	97006	97132	97174	97370
96852	96944	97008	97136	97228	
96854	96948	97010	97138	97230	
96860	96970	97012	97140	97232	

Operations on the Male Genital System

97600	97610	97612	97630	97634	
97606	97611	97624	97632	97636	

Operations on the Female Genital System

97784	97832	97854	97866	97942	97984
97794	97834	97856	97930	97948	
97798	97838	97858	97932	97950	
97820	97844	97860	97934	97952	
97822	97850	97862	97938	97954	
97830	97852	97864	97940	97982	

Operations on the Endocrine System

98020	98024	98027	98040	98044	98048
98022	98026	98028	98042	98046	98050

SURGICAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SPECIAL PROCEDURES				
90008	Examination under general anaesthesia (when not elsewhere specified and when sole procedure) (IOP)		28.34	4
90010	Insertion of radium			4
90012	General anaesthetic for CAT Scan/MRI			5
90014	Anaesthetic wake-up test	add		6
90016	Fibreoptic intubation	add		10
90018	One-lung anaesthesia	add		6
90020	Anaesthesiologist or assistant standby at the request of the attending physician (IC)	27.77		3
90022	Monitoring under IV sedation			4
90024	Anaesthesiology additional fee for children under 1 year of age	add		3
90026	Anaesthesiology additional fee for adults 70 or older	add		1
90028	For patients of any age with an incapacitating systemic disease that is a constant threat to life (ASA IV) or to a moribund patient who is not expected to survive for 24 hours, with or without the operation (ASA V)			4
90030	For patients undergoing anaesthesia in the prone or sitting position	add		4
90032	For patients undergoing anaesthesia who weigh less than 5 kg	add		3
90034	Controlled hypotension	add		10
90036	Malignant hyperthermia set up and management	add		5
90038	Anaesthesiology management for the emergency relief of acute upper airway obstruction	add		10
90040	Anaesthetic begun and operation cancelled prior to commencement of surgery	27.77		4
90042	Patient with body mass index (BMI) greater than 40 who receives general anaesthesia	add		2

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
<u>Incision (IOP)</u>				
Abscess or Haematoma				
Incision under local anaesthetic				
90100	- subcutaneous - 1		28.19	
90102	- 2		30.82	
90104	- 3 or more		41.35	
90106	- perianal		20.39	
90108	- ischiorectal or pilonidal		44.98	
90110	- palmar or plantar spaces		44.98	
Incision under general anaesthetic				
90112	- subcutaneous - 1		44.98	4
90114	- 2 or more		73.73	4
90116	- perianal		66.00	4
90118	- ischiorectal or pilonidal		108.00	4
90120	- palmar or plantar spaces		79.77	4
Comedones, Acne Pustules, Millia				
90122	- ten or less		3.97	
90124	- eleven or more		13.82	
Foreign body removal – not to be claimed for the routine removal of sutures within 42 days of surgery				
90126	- removal under local anaesthetic		25.25	
90128	- removal under general anaesthetic	27.77	90.07	4
90130	- complicated removal	37.03	IC	4
90132	Intramuscular abscess or haematoma		103.10	4
90134	Aspiration of superficial lump for cytology		28.66	
Biopsy(s)				
90140	- when sutures are used *		29.60	
90141	- when sutures are not used (maximum of 1 unit)		29.60	
90142	- extensive, complicated or requiring general anaesthetic, when sole procedure	IC	IC	4
90144	- for malignant hyperthermia, 3 or more (fee code 90036 <u>not</u> payable in addition)		155.11	10

* Fee code 90140 may be allowed more than once on an IC basis if medically necessary (in order to make a diagnosis or plan treatment), to biopsy more than one lesion or to obtain a second biopsy from an extensive lesion. If claimed, may be allowed with chemical treatment of lesion (code 90560).

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Assist	FP/ Spec.	Anaes.
Excision			
When excision of benign or malignant lesions are corrected by advancement, rotation, transposition, "Z" plasty, flap or graft, claim appropriate benefit listed under Repair Section instead of excision benefits.			
Excision of Benign Lesions			
The fee codes for excision, electrocoagulation, curetting, cryosurgery and laser surgery of benign lesions are specific to the lesions identified in the definition. Payment for treatment of unlisted benign lesions requires prior approval from MCP.			
Single or multiple sites, uni or bilateral (with or without biopsy)			
<u>Group 1</u> – verruca, papilloma, benign keratosis, pyogenic granuloma, spider naevus, Campbell de Morgan spots (IOP)			
Removal by excision and suture			
90150		20.00	4
90152		26.50	4
90154		44.25	4
Paring of warts and corns without complete removal			
Removal by electrocoagulation and/or curetting and/or cryosurgery and/or laser surgery			
90156		10.55	4
90158		15.85	4
90160		26.20	4
<u>Group 2</u> – naevus (IOP)			
Removal by excision and suture			
90162		18.59	4
90164		25.29	4
90166		38.49	4
90168	IC	IC	IC
<u>Group 3</u> – palmar or plantar verruca (IOP)			
Paring of warts and corns without complete removal			
Removal by excision and suture			
90170		26.05	4
90172		38.90	4
90174		64.60	4
Removal by electrocoagulation, and/or curetting and/or cryosurgery and/or laser surgery			
90176		28.89	4
90178		30.30	4
90180		59.95	4

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
<u>Excision of Benign Lesions (Cont'd)</u>				
<u>Group 4 – cyst, haemangioma, lipoma (IOP)</u>				
Face or neck				
Local anaesthetic				
90182	- single lesion		38.50	
90184	- 2 lesions		67.80	
90186	- 3 or more lesions		78.00	
General anaesthetic				
90188	- single lesion	27.77	65.35	4
90190	- 2 lesions	27.77	98.55	4
90192	- 3 or more lesions	27.77	117.40	4
90194	- extensive or massive	27.77	IC	5
Other Areas				
Local anaesthetic				
90196	- single lesion		32.00	
90198	- 2 lesions		45.00	
90200	- 3 or more lesions		60.00	
General anaesthetic				
90202	- single lesion	27.77	50.76	4
90204	- 2 lesions	27.77	66.57	4
90206	- 3 or more lesions	27.77	109.06	4
90208	- extensive or massive	27.77	IC	5
Lipoma				
90210	- 5 to 10 cm.	27.77	80.00	4
90212	- over 10 cm.	27.77	160.00	5
Congenital dermoid cyst				
90214	- adult	27.77	126.22	4
90216	- infant or child	27.77	203.94	4
90218	- midline, e.g. nasal	27.77	276.79	4
90220	Giant cell tumour	27.77	200.00	4
Excision of Pressure sore or decubitus ulcer (IOP)				
90224	- minor, less than 1 cm. average diameter		33.93	4
90226	- intermediate, 1-5 cm. average diameter		72.75	4
90228	- major or complex		IC	5
Pilonidal cyst				
90234	- simple excision or marsupialization	27.77	200.95	4
90236	- excision and skin shift	27.77	280.00	4
Inguinal, perineal or axillary skin and sweat glands for hyperhidrosis and/or hidradenitis				
90240	- unilateral	27.77	248.80	5
90242	- with skin graft(s) or rotation flap(s)	27.77	338.60	6

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
<u>Excision of Malignant and Premalignant Lesions</u>				
Single or multiple sites, uni or bilateral (Includes biopsy of each lesion)				
Simple excision				
Face or Neck				
90246	- single lesion	27.77	92.15	4
90248	- 2 lesions	27.77	139.20	4
90250	- 3 or more lesions	27.77	242.80	4
Other areas				
90252	- single lesion	27.77	59.03	4
90253	- 2 lesions	27.77	97.10	4
90254	- 3 or more lesions	27.77	194.20	4
90256	- in hospital excision tumour for tumour free margins with frozen section (payable in addition to excision or repair fees)		56.65	
Curettage, electrodesiccation or cryosurgery of malignant and premalignant lesions				
Face or Neck				
90258	- single lesion	27.77	62.61	4
90260	- 2 lesions	27.77	101.20	4
90262	- 3 or more lesions	27.77	202.30	4
Other areas				
90264	- single lesion	27.77	49.30	4
90266	- 2 lesions	27.77	81.20	4
90268	- 3 or more lesions	27.77	186.83	4
90270	Chemosurgery (Mohs technique)		IC	IC
<u>Repair</u>				
90300	Severe contracture release by excision of scar, e.g., joint		100.00	4
Debridement and Dressing (IOP) (<u>not</u> chargeable in addition to any surgical procedure unless complications require such care in excess of the usual post-operative care)				
- minor				
90304	- major		VF 14.05	
90306	- requiring general anaesthetic	37.03	50.40	4
90308	- extensive	37.03	IC	5

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
Repair (Cont'd)				
Suture of Laceration (IOP)				
90310	- up to 5 cm.		20.03	4
90312	- up to 5 cm. if on face and/or requires tying of bleeders and/or closure in layers		41.27	4
90314	- 5.1 to 10 cm.		36.14	4
90316	- 5.1 to 10 cm. if on face and/or requires tying of bleeders and/or closure in layers			4
90318	- 10.1 to 15 cm.		72.40	4
90320	- 10.1 to 15 cm. if on face and/or requires tying of bleeders and/or closure in layers		51.21	4
90322	- more than 15 cm.		102.88	4
90324	- if inhalation general anaesthesia (other than 50% N ₂ O/O ₂ mixture) is used		IC	4
90326	- when rendered in private office or home		55.83	
			10.51	
Note:				
The above benefits include the use of sutures, local anaesthetic and tetanus toxoid.				
Muscle Repair				
90330	- simple muscle repair to include repair of involved skin	27.77	88.60	4
90332	- complex	37.03	IC	6
Scar Revision –any method of closure				
Up to 2.5 cm.				
90336	- face or neck	27.77	115.60	4
90338	- other areas	27.77	77.35	4
2.6 to 5 cm.				
90340	- face or neck	27.77	194.85	4
90342	- other areas	27.77	130.10	4
5.1 to 10 cm.				
90344	- face or neck	27.77	277.90	5
90346	- other areas	27.77	185.60	5
90348	Greater than 10 cm.	37.03	IC	6
Tissue Expanders				
90352	Insertion by separate incision	27.77	304.10	5
90354	Removal of tissue expander injection port under general anaesthetic (IOP)	55.54	75.45	6
90356	Removal of tissue expander injection port under local anaesthetic (IOP)		37.70	8
90358	Percutaneous inflation of tissue expander, per visit (IOP)		23.05	
90360	Inflation of each additional expander to a maximum of 3		11.55	
90362	Replacement of tissue expander by permanent prosthesis (IOP)		195.85	4

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
Repair (Cont'd)				
Skin Flaps				
Advancement flap fees are intended to include payment for excision of a lesion if this is the technique of closure				
Defect 2.1 to 5 cm.				
90370	- face or neck	27.77	89.95	4
90372	- other areas	27.77	67.40	4
Defect 5.1 to 10 cm.				
90374	- face or neck	27.77	247.15	5
90376	- other areas	27.77	161.75	5
90378	Defect larger than 10 cm.	37.03	IC	6
Note: The medical necessity for a single or multiple flap occurs when a defect cannot be closed by elevating or undermining the edges and suturing subcutaneous tissue and skin.				
An advancement flap does not qualify for the listings above unless the repair involves at least one level of deep sutures and each edge of the defect is undermined a distance equal to or greater than:				
(a) 1 cm – nose, ear, eyelid, lip				
(b) 1.5 cm – other face and neck				
(c) 2.5 cm – rest of body				
The listings are only to be used where the dissection meets the criteria above, whether the advancement involves one or both sides of the wound. If the wound can be closed in a straight line, 5 cm or less in length, a tissue advancement flap should not ordinarily be required.				
Rotations, Transpositions, "Z" plasties (includes undermining)				
Defect less than 2cm.				
90382	- face or neck	27.77	203.70	4
90384	- other areas	27.77	133.40	4
Defect 2.1 to 5 cm.				
90386	- face or neck	27.77	335.15	4
90388	- other areas	27.77	205.30	4
Defect 5.1 to 10 cm.				
90390	- face or neck	37.03	477.45	4
90392	- other areas	37.03	318.45	4
90394	Defect larger than 10 cm.	37.03	IC	5
Pedicle Flaps				
90398	Small, e.g., cross finger	37.03	146.05	4
90400	- each subsequent stage	37.03	108.29	4
90402	Intermediate, e.g. cervical finger	37.03	293.75	5
90404	- each subsequent stage	37.03	221.58	5
90406	Large, e.g., cross leg, deltopectoral, forehead	37.03	416.30	6
90408	- each subsequent stage	37.03	311.45	6
90410	Preparation of a contracted recipient site, add to 90402 or 90406	27.77	134.75	4
90412	Delay of tube or pedicle	27.77	62.65	4
90414	Delay, intermediate flap	27.77	131.35	4
90416	Delay, major flap	37.03	289.58	5

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
Repair (Cont'd)				
Myocutaneous flaps (to include closure by any means)				
90420	Sternomastoid, tensor fascia lata, gluteus maximus, gracilis, satorius, rectus femoris, gastrocnemius, trapezius	27.77	613.30	5
90422	Pectoralis major, latissimus dorsi, unilateral rectus abdominus	37.03	734.95	6
90424	Lower transverse rectus abdominus flap	55.54	984.55	8
90426	- repair of abdominal defect - same surgeon		321.00	
90428	- different surgeon		377.65	
90430	Myocutaneous – osseous flaps	55.54	720.00	8
90432	Other	IC	IC	8
Skin Grafts (includes taking the skin for grafting)				
Split Thickness Grafts				
90440	Very minor, very small areas		92.30	4
90442	Minor, medium sized areas, e.g. small or average varicose ulcer, breast, etc.	27.77	140.25	4
90444	Intermediate or large areas on the trunk, arms, legs, etc.	37.03	259.10	4
90446	Major or complex areas on the face, neck, hands, etc.	37.03	527.27	5
90448	Extensive major, very large areas	37.03	567.95	6
Full Thickness Grafts				
90450	Minor – less than 1 cm. average diameter		93.41	4
90452	Intermediate – 1 to 5 cm. average diameter	27.77	178.90	4
90454	Major – over 5 cm.	46.29	280.15	6
90456	Complex – eyelid, nose, lip, face	37.03	263.95	6
90460	Appendage or tissue revascularization involving microanastomosis with or without micro neuro-anastomosis		IC	IC
90462	- revision of above	IC	IC	IC
Stasis Ulcer				
90464	- with skin graft – per leg	27.77	195.85	5
90466	- multiple ligation and skin graft – per leg	46.29	341.55	5
Neurovascular Island Transfer				
90470	- minor, e.g., fingertip	27.77	140.25	4
90472	- intermediate finger to thumb	37.03	259.20	5
90474	- major foot to heel	37.03	430.85	6
Free Island Flaps				
Skin and subcutaneous tissue				
90490	- elevation and closure of donor site	92.57	874.60	10
90492	- preparation of microvascular site		925.85	
90494	- transplant with microvascular anastomosis		925.85	
Innervated skin and subcutaneous tissue flap				
90496	- elevation	92.57	900.10	10
90498	- preparation of site		900.10	
90500	- transplantation		841.50	

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
Repair (Cont'd)				
Skin Grafts (includes taking the skin for grafting) (Cont'd)				
Free Island Flaps (Cont'd)				
Skin and muscle flap				
90502	- elevation	92.57	874.60	10
90504	- preparation of site		925.85	
90506	- transplantation		874.60	
Muscle with tendon and nerve				
90508	- elevation	92.57	1,035.55	10
90510	- preparation of site		1,035.55	
90512	- transplantation		1,035.55	
Bone flap				
90514	- elevation	92.57	765.50	10
90516	- preparation of site		810.00	
90518	- transplantation		900.10	
Skin and bone flap				
90520	- elevation	92.57	1,048.60	10
90522	- preparation of site		1,048.60	
90524	- transplantation		1,048.60	
Free toe or finger				
90526	- elevation	92.57	918.30	10
90528	- preparation of site		918.30	
90530	- transplantation		1,080.10	
90532	Revision of free island flaps	92.57	IC	10
90534	Flaps other than above	IC	IC	IC
90540	Digital reimplantation	74.06	1,439.40	10
Destruction				
Finger or toenail (IOP)				
Simple, partial or complete				
90550	- 1		33.10	4
90552	- multiple		35.70	4
Radical, including destruction of nail bed				
90554	- 1		62.75	4
90556	- multiple		74.10	4
Chemical and/or cryotherapy treatment of minor skin lesions (IOP)				
90560	- 1 or more lesions, per treatment		11.65	
Plastic planing, dermabrasion – face for acne. Maximum per session equivalent to rate for whole face				
90576	- forehead or nose or chin or single cheek		93.20	4
90578	- both cheeks		189.00	4
90580	- whole face		288.00	4
90582	- single area, e.g., trauma scar		51.65	4
90584	Rhinophyma, removal by shaving		231.40	4

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
Repair (Cont'd)				
Webbed Fingers				
90590	- 1 web space	37.03	400.00	5
Webbed Toes				
90596	- 1 web space	37.03	250.00	4
Burns				
Resuscitation – major burn				
90600	- initial 24 hours (IOP)		106.25	
90602	- continuing care (up to 3 days) per day, (IOP)		53.10	
For burn care requiring Anaesthesiologist's and/or assistant's services, the following fees apply:				
90610	Minor burns – up to <u>15%</u>	37.03		5
90612	Moderate burns – <u>16% to 30%</u>	55.54		10
90614	Major burns – more than <u>30%</u>	74.06		15
90620	Debridement and excision, per % of total body treated (other than hand, head or neck)		29.65	
Debridement and excision				
90622	- hand, each digit		28.90	
90624	- dorsum palm – each		47.95	
90626	- nose, cheek, lip, ear, forehead, scalp, neck, eyelid –each		28.90	
90640	Grafting of burn, per % of total body treated (other than hand, head or neck)		59.50	
Graft of burn				
90644	- hand, each digit		71.38	
90646	- palm, dorsum – each		142.88	
90648	- nose, lip(s) – each		238.19	
90650	- cheek(s) – forehead – each		238.19	
90652	- ear		238.19	
90654	- eyelid		238.19	
90656	- scalp, less than <u>10%</u>		119.13	
90658	- up to <u>50%</u>		297.75	
90660	- over <u>50%</u>		IC	
90662	- neck, less than <u>10%</u>		119.13	
90664	- up to <u>50%</u>		261.86	
90666	- over <u>50%</u>		IC	
Subdermal Birth Control Devices (IOP)				
90668	- implantation		40.00	
90669	- explantation		60.00	

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Assist	FP/ Spec.	Anaes.
------	--------	--------------	--------

Plastic Surgery Procedures

The setting of fees covering the various procedures of plastic surgery is very difficult, if not an impossible problem. The charging of the repair of lacerations by the inch, or of free grafts by the square inch has no legal basis since the importance of location and function is not considered. Since many procedures are divided into stages which have to be considered in assessing a fee, it is felt that all such plastic surgical procedures should be classed by the responsible specialist as very minor, minor, intermediate, major, or extensive major. Fees should be charged according to procedures set forth in the tariff, except in cases which are difficult to define.

All claims for plastic surgery procedures must be accompanied by an IC form stating the medical indication for the procedure and giving a description of the procedure as performed. A copy of the operative report may be forwarded in place of the description.

The fee for each class of plastic surgical procedures is as follows:

90670	Very minor plastic surgery procedures		97.68	4
90672	Minor	27.77	148.40	4
90674	Intermediate	37.03	274.25	4
90676	Major	37.03	410.57	5
90678	Extensive major	37.03	602.04	6

SURGICAL PROCEDURES

OPERATIONS ON THE BREAST

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
Incision				
90680	Needle biopsy – 1 or more (IOP)		24.31	
90682	Aspiration of cyst – 1 or more (IOP)		22.30	
	Drainage of intramammary abscess single or multiloculated (IOP)			
90684	- drainage under local anaesthetic		22.30	
90686	- drainage under general anaesthetic		61.20	4
Excision				
90700	Tumor or tissue for biopsy (single or multiple – same breast)	27.77	169.95	4
90701	- with wire/needle localization		76.38	
90702	Partial mastectomy or wedge resection	27.77	269.40	4
90704	- with radical axillary node dissection		383.12	2
	Mastectomy –male (benign)			
90706	- unilateral – simple	27.77	241.20	4
90708	- subcutaneous with nipple preservation	37.03	273.95	5
	Mastectomy –female (with or without biopsy)			
90710	- simple	27.77	301.37	5
90712	- subcutaneous with nipple preservation	27.77	428.59	5
90714	Mastectomy, radical or modified radical (with or without biopsy)	27.77	562.80	6
Repair				
	Post-mastectomy breast reconstruction			
90720	- breast mound creation by prosthesis and/or soft tissue	37.03	350.00	5
90724	- breast skin reconstruction by local flaps or grafts	37.03	438.58	5
90726	- with breast mound creation by prosthesis and/or soft tissue..... add		101.78	
90728	- revision of breast mound	27.77	253.40	4
	Nipple-areolar			
90730	- preservation and tissue banking	27.77	116.57	4
90732	- re-implantation of banked nipple-areola	27.77	135.99	4
90734	- nipple reconstruction by grafts	27.77	300.00	4
90740	Reduction mammoplasty (female, to include nipple transplantation or grafting) – unilateral	46.29	490.10	7
90744	Augmentation mammoplasty – unilateral	37.03	198.92	4
90748	Removal of breast prosthesis and/or fibrous capsule (IOP)	27.77	150.00	4
	Breast capsulotomy, closed (IOP)			
90750	- breast capsulotomy without anaesthetic		12.25	
90752	- breast capsulotomy under general anaesthetic	27.77	78.68	4
90754	Open capsulectomy with or without replacement of breast prosthesis (IOP) ...	27.77	195.95	4
90756	Myocutaneous flaps, pectoralis major, latissimus dorsi, unilateral rectus	37.03	729.07	6

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
GENERAL FEES				
Bone/Fascial/Dermis Grafts				
Note: The benefit for obtaining a bone graft is <u>not</u> to be claimed in cases of pseudoarthrosis repair, fusions or for listings in which the bone grafting is included.				
90800	Autogenous - separate incision		86.30	
90802	- same incision		58.45	
90804	- different surgeon (IOP)		193.00	
90806	Homogenous – bank		25.15	
90808	Allograft - donor - <u>85%</u> of excision fee		IC	
90810	- cadaver – each long bone		140.90	
Fixation				
90830	Methyl methacrylate (not arthroplasty)		57.76	
90832	Rigid external fixation (excluding casts) for closed reduction		55.93	
90834	Cast – bracing with closed reduction		55.93	
90836	Percutaneous pinning		41.95	
90838	Rigid external fixation – pseudoarthrosis		76.10	
Removal of internal fixation device				
90840	- removal under general anaesthetic	27.77	158.65	4
90842	- removal under local anaesthetic		104.27	
90844	Removal of extensive external fixation device under general anaesthetic		48.25	4
90846	Insertion traction pin – excludes fractures and dislocations (IOP)		33.35	
Wound Care				
90860	Secondary closure		97.35	
90862	Closed irrigation during a surgical procedure		61.41	
90866	Excision of foreign body		107.70	4
Electrical Stimulation				
90870	External or internal (IOP)		187.84	4
Casts (IOP)				
Note: Corrective splints <u>must</u> be “corrective” to qualify for benefits. The corrective splint listings are <u>not</u> applicable to simple immobilization such as with a Jones bandage or a metal finger splint following soft tissue injury.				
90900	Finger		11.96	
90902	Hand		17.95	4
90904	Arm, forearm or wrist		28.72	4
90906	Foot		17.95	4
90908	Below knee, knee splints (Stove pipe, etc.)		30.65	4
90910	Whole leg (mid-thigh to toes)		34.83	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
GENERAL FEES (Cont'd)				
Casts (IOP) (Cont'd)				
90912	Toes		11.96	
90914	Head and torso	27.77	116.85	4
90916	Shoulder spica	27.77	116.85	4
90918	Body cast		69.27	4
90920	Hip spica - unilateral		116.85	4
90922	- bilateral		146.23	4
90924	Wedging of casts in other than fracture treatment		11.96	
90926	Application of Unna's paste		17.95	
90928	Application of cast brace (must include hinge)		81.23	
90930	Removal of plaster (not associated with fractures or dislocations within 4 weeks of initial treatment)		11.96	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
HAND AND WRIST				
Amputation				
90950	Phalanx		161.45	4
90952	- each additional	add	94.60	
90954	Metacarpal or metaphalangeal joint		190.20	4
90956	- each additional	add	94.60	
90958	Transmetacarpal 2 nd or 5 th ray		279.35	4
90960	Hand – all metacarpals	27.77	289.50	4
90962	Wrist	37.03	281.79	5
Arthrodesis				
90970	Finger, thumb	27.77	256.15	4
90972	Wrist	27.77	379.35	4
Arthroplasty				
90980	Wrist - interposition	27.77	374.00	5
90982	- total	55.54	415.05	6
90984	Removal only	27.77	187.84	6
90986	Hand - interposition - single	27.77	247.16	5
90988	- multiple	27.77	447.11	6
90990	Single joint – total	27.77	282.71	5
90992	Multiple joints – total max	27.77	774.90	6
90994	Removal only	27.77	140.90	4
90996	Carpal replacement	27.77	322.05	5
90998	Revision of arthroplasty	add	139.82	
Arthroscopy				
91010	Diagnostic arthroscopy (sole procedure)	27.77	178.86	4
91011	Wrist arthroscopy setup, includes when rendered debridement, synovectomy, synovial biopsy, removal of loose body(ies) and/or screw, drilling of defect or microfracture, and/or wrist ganglion debridement	55.54	400.00	7
Notes:				
1. A wrist procedure listed in the Hand and Wrist section of the Schedule performed arthroscopically is eligible for payment in addition to 91011 if that procedure is not described as a component of 91011 or described by an add-on code to 91011.				
2. Arthroscopic add-on codes listed below are not eligible for payment in addition to 91011 when the service described by the code is a generally accepted component of a procedure described in Note #1.				
91025	Arthroscopy of midcarpal and/or distal radio-ulnar joint, through separate portals, to 91011	add	192.00	
91026	Pinning of osteochondral fragment, to 91011	add	251.55	
Note:				
Fracture procedures are not eligible for payment with 91026 for the same fracture.				

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
HAND AND WRIST (Cont'd)				
Arthroscopy (Cont'd)				
91029	Triangular fibrocartilage complex repair, to 91011	add	350.65	
91030	Soft tissue capsular release, for contractures, without bone procedure, to 91011	add	251.55	
91032	Synovectomy for inflammatory arthritis requiring a minimum of 90 minutes to resect, to 91011	add	326.55	
Notes:				
1. Synovectomy less than 90 minutes in duration is included in 91011.				
2. Only one of 91030 or 91032 is eligible for payment same patient same day.				
Arthrotomy				
91040	Finger		168.00	4
91042	Wrist	27.77	207.26	4
Biopsy				
91050	Bones - punch, x-ray control (IOP)		70.45	4
91052	- open biopsy or taking of bone graft by other than operating surgeon (IOP)	37.03	144.80	4
91054	Joint - via arthroscope		10.65	
91056	- needle (IOP)		47.43	
91058	- open finger		163.05	4
91060	- open wrist	27.77	207.26	4
91062	Muscle (IOP)		103.05	4
Decompression – Denervation				
91070	Decompression median nerve at wrist	27.77	191.62	4
91072	Exploration and/or decompression and/or transposition and/or neurolysis of major nerve (excluding median nerve at wrist)	37.03	256.15	4
Incision and Drainage (e.g. Osteomyelitis)				
Incision and drainage				
91080	- phalanx/metacarpal/carpus	27.77	182.90	4
Sequestrectomy				
91082	- phalanx/metacarpal/carpus	27.77	144.80	4
Saucerization and bone graft				
91084	- phalanx/metacarpal/carpus	27.77	235.76	4
91086	Incision and drainage - joint (finger)		168.00	4
91088	- joint (wrist)	27.77	212.50	4
91090	Tendon sheath	27.77	225.00	4
Examination/Manipulation				
91100	Manipulation – hand/wrist – under general anaesthetic (IOP)		24.10	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
HAND AND WRIST (Cont'd)				
Excision – Bone				
91110	Proximal row carpectomy	27.77	329.66	5
91112	Carpal – bone (1)	27.77	214.45	4
91114	Dorsal exostosis (triquetrum)	27.77	204.64	4
91116	Radial styloid	27.77	228.12	4
91118	Phalanx/metacarpal	27.77	207.58	4
91120	Bone tumour	IC	IC	IC
Excision – Joint				
Synovectomy/capsulectomy/debridement				
91130	- finger joint	27.77	226.40	4
91132	- 2 or more joints	27.77	339.65	4
91134	Synovectomy – extensor or flexor tendons		224.45	4
91136	Synovectomy/debridement – wrist	27.77	342.55	4
91138	Radio-ulnar meniscectomy	27.77	225.60	4
Excision – Muscle and Tendon				
91150	Muscle - simple	27.77	187.84	4
91152	- complex	37.03	471.52	6
Tendon sheath				
91154	- single	27.77	235.76	4
91156	- each additional (max of 1)		92.60	
Excision – Soft Tissue				
91158	Excision of fascia for Dupuytren's (palmar fibromatosis), single ray, with or without flaps	55.54	322.15	7
91160	- excision of fascia for Dupuytren's, one or more additional rays, to 91158 add		273.85	
91162	- use of skin grafts, or revision surgery (with or without skin grafts), to 91158			add 30%
Notes:				
1. 91158 is not payable for treatment of Dupuytren's by aponeurotomy.				
2. A maximum of one 91158 is eligible for payment per limb, per day.				
3. Services listed under "Skin Flaps and Skin Grafts" are not eligible for payment with 91158.				
4. 91158, 91160 and 91162 include the palmar and digital components of the Dupuytren's procedure, when rendered.				
Excision – Ganglion				
91170	Simple or complex	27.77	177.80	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
HAND AND WRIST (Cont'd)				
Reconstruction – Bone				
Osteotomy				
91180	- phalanx – terminal		173.03	4
91182	- phalanx – middle, proximal or metacarpal	27.77	193.20	4
91184	- each additional		158.65	
	add			
91186	Pseudoarthrosis - phalanx, metacarpal	27.77	260.75	4
91188	- scaphoid.....	27.77	500.00	4
Reconstruction – Ligaments				
91200	Simple/single repair – wrist	27.77	301.60	4
91202	Extensive/multiple repair – wrist	27.77	511.45	4
91204	Metacarpal phalangeal repair	27.77	316.75	4
Reconstruction – Tendon				
91210	Tenoplasty - 1	27.77	223.65	4
91212	- each additional		77.05	
	add			
91214	Tendon graft – 1	27.77	324.86	4
91216	- each additional		259.85	
	add			
91218	Reconstruction of flexor tendon pulley, per finger		97.35	4
91220	Silicone rod insertion - 1	27.77	294.20	4
91222	- each additional		245.90	
	add			
91224	Transplant/transfer - single	27.77	284.95	4
91226	- each additional		236.10	
	add			
91228	Tendon repair - extensor - single		164.10	4
91230	- each additional (same incision)		70.95	
	add			
91231	- each additional (separate incision)		118.57	
	add			
91232	Tendon repair - flexor - single	27.77	307.60	4
91234	- each additional (same incision)		128.95	
	add			
91235	- each additional (separate incision)		222.24	
	add			
	Mallet finger - closed		VF	
91238	- K-wire		130.68	4
91240	- open	27.77	147.20	4
	Boutonniere - closed		VF	
91242	- open	27.77	156.51	4
91244	- late	27.77	246.65	4
Reconstruction – Extremities				
91250	Pollicization	55.54	577.14	6
91252	Digital reimplantation involving microvascular and neuro anastomosis	74.06	1,548.15	8
91254	Revision of 91250 or 91252	74.06	IC	8
91258	Reconstruction and plastic repair of traumatically amputated extremities	74.06	IC	8

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
HAND AND WRIST (Cont'd)				
Release - Tendon				
91270	Tenolysis - flexor and/or extensor tendon of 1 digit	27.77	194.05	4
91272	- each additional digit add		165.20	
91274	Flexor tenolysis with pulley preservation	27.77	309.00	4
	Tenotomy or fasciotomy (closed) (IOP)			
91276	- finger - 1		49.20	4
91278	- 2		72.35	4
91280	- 3 or more		99.15	4
91282	- palmar or plantar		73.70	4
	Tendon release (open)			
91284	- finger, palm		156.50	4
91286	- wrist	27.77	190.08	4
91288	- more than 1 add		140.90	
Reduction – Fractures				
91300	Phalanx - no reduction, rigid immobilization		49.20	
91302	- closed		99.25	4
91304	- each additional add		22.25	
91306	- open	37.03	298.45	4
91307	- extensive debridement of compound fracture add		149.23	
91308	Metacarpal - no reduction, 1 or more, rigid immobilization		49.20	
91310	- closed, 1 or more		99.25	4
91312	- open	37.03	262.60	4
91314	- each additional (open) add		142.90	
91315	- extensive debridement of compound fracture add		131.30	
91316	Intra-articular - closed		119.75	
91318	- open	37.03	335.80	4
91319	- extensive debridement of compound fracture add		82.12	
91320	Bennett's - no reduction, rigid immobilization		48.51	
91322	- closed	27.77	119.80	4
91324	- open	37.03	237.87	4
91325	- extensive debridement of compound fracture add		118.94	
91326	Carpus - no reduction, rigid immobilization		49.20	
91328	- closed, 1 or more		115.10	4
91330	- open, 1 or more	37.03	346.15	4
91331	- extensive debridement of compound fracture add		173.08	
91332	Scaphoid - no reduction, rigid immobilization		49.20	
91334	- open	37.03	480.00	4
91336	- excision	37.03	187.90	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
HAND AND WRIST (Cont'd)				
Reduction - Dislocations				
91350	Finger - closed - 1		57.50	4
91352	- each additional		10.25	
91354	- open	27.77	196.50	4
91355	- extensive debridement of compound fracture		98.25	
91356	Metacarpal/phalangeal - closed - 1		57.50	4
91358	- each additional		10.25	
91360	- open	27.77	181.85	4
91361	- extensive debridement of compound fracture		90.93	
91362	Carpal - closed		128.05	4
91364	- open	27.77	241.30	4
91365	- extensive debridement of compound fracture		120.65	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
ELBOW AND FOREARM				
Amputation				
91370	Through radius and ulna	37.03	306.30	5
91372	Elbow disarticulation	37.03	289.50	5
Arthrodesis				
91380	Elbow	27.77	400.00	4
Arthroplasty				
91390	Ulna replacement (lower end)	27.77	296.90	4
91392	Implant radial head	27.77	301.55	4
91394	Removal of total replacement	27.77	402.75	7
91396	Complete arthroplasty replacement	55.54	619.90	8
91398	Interposition arthroplasty	55.54	435.20	7
91400	Revision of elbow arthroplasty		312.92	
Arthroscopy				
91410	Diagnostic arthroscopy (sole procedure)	27.77	178.86	4
91411	Elbow arthroscopy setup, includes when rendered debridement, synovectomy, synovial biopsy, removal of loose body(ies) and/or screw, drilling of defect or microfracture, and/or arthroscopic epicondylar release	55.54	400.00	7
Notes:				
1. An elbow procedure listed in the Elbow section of the Schedule performed arthroscopically is eligible for payment in addition to 91411 if that procedure is not described as a component of 91411 or described by an add-on code to 91411.				
2. Arthroscopic add-on codes listed below are not eligible for payment in addition to 91411 when the service described by the code is a generally accepted component of a procedure described in Note #1.				
91426	Pinning of osteochondral fragment, to 91411		251.55	
Note: Fracture procedures are not eligible for payment with 91426 for the same fracture.				
91430	Osteochondroplasty (extensive bone and arthrofibrotic tissue removal requiring a minimum of 2 hours to resect), to 91411		500.00	
91432	Soft tissue capsular release for contractures without bone procedure, to 91411		251.55	
91434	Synovectomy for inflammatory arthritis requiring a minimum of 90 minutes to resect, to 91411		326.55	
Notes:				
1. Only one of 91430, 91432 or 91434 is eligible for payment same patient same day.				
2. Synovectomy less than 90 minutes in duration is included in 91411.				
3. Osteochondroplasty less than 2 hours in duration is included in 91411.				

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
ELBOW AND FOREARM (Cont'd)				
Arthrotomy				
91440	Elbow, loose body, etc.	27.77	199.55	4
Biopsy				
91450	Bone - needle (IOP)		72.35	
91452	- open (IOP)	37.03	144.80	4
91454	Joint - via arthroscope		10.65	
91456	- open	27.77	171.45	4
91458	Muscle/soft tissue (IOP)		103.05	4
Decompression/Denervation				
91470	Fasciotomy for compartments syndrome (not including secondary closure wound)	27.77	320.20	4
91472	Secondary closure		103.05	4
91474	Catheter - insertion (IOP)		49.20	
	- monitoring		VF	
91478	Exploration and/or decompression and/or transposition and/or neurolysis of ulnar nerve (elbow)	37.03	215.35	4
91480	Denervation - elbow	27.77	258.00	4
Incision and Drainage (osteomyelitis)				
91490	Acute, incision and drainage	27.77	302.55	4
91492	Sequestrectomy	27.77	355.35	4
91494	Saucerization and bone grafting	27.77	452.90	4
91496	Soft tissue or bursa, incision and drainage		97.35	4
91498	Elbow, incision and drainage	27.77	199.55	4
Examination/Manipulation				
91510	Manipulation - elbow and forearm - under general anaesthetic (IOP)		23.02	4
Excision – Bone				
91520	Radial head	27.77	217.95	4
91522	Radial styloid	27.77	234.75	4
91524	Ulna lower end	27.77	193.00	4
91526	Olecranon	27.77	207.90	4
91528	Olecranon with fascial repair	27.77	309.00	4
Excision – Bursae				
91540	Olecranon	27.77	101.25	4
Excision - Joint Contents				
91550	Synovectomy/capsulectomy/debridement, etc.	27.77	311.85	4
Excision – Muscles				
91560	Myositis ossificans	37.03	289.50	5
91562	Foreign body removal		107.70	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
ELBOW AND FOREARM (Cont'd)				
Excision - Soft Tissues Tumours				
91570	- superficial		196.05	4
91572	- deep	46.29	484.35	6
Excision - Bone Tumours				
91580	Exostosis	37.03	165.20	4
91582	Simple excision	37.03	289.50	4
91584	Extensive with replacement	37.03	677.50	6
Reconstruction - Bone – Pseudoarthrosis				
91590	Radius or ulna	27.77	304.40	4
91592	Radius and ulna	27.77	411.20	4
Reconstruction - Bone – Osteotomy				
91600	Radius or ulna	27.77	297.85	4
91602	Radius and/or ulna and reconstruction congenital abnormality, synostosis, etc.	27.77	398.10	4
Reconstruction - Fascial Defects				
91610	- small	27.77	144.80	4
91612	- large with or without synthetic graft or rotation flap	37.03	290.55	5
Reconstruction – Ligaments				
91620	Simple/single repair	27.77	301.60	4
91622	Extensive/multiple repair	27.77	511.45	4
Reconstruction – Tendons				
91630	Suture extensor tendon - single	27.77	164.10	4
91632	- each additional..... add		70.95	
91634	Suture flexor tendon - single	27.77	307.60	4
91636	- each additional		128.95	
91638	Tenoplasty - single	27.77	217.91	4
91640	- each additional		74.64	
91642	Tenolysis - single	27.77	196.93	4
91644	- each additional (max. of 2)		84.86	
Transposition/transplantation/transfer				
91646	- single	27.77	278.08	4
91648	- each additional (max. of 1)		89.70	
91650	Steindler flexoplasty	27.77	336.49	5
Release				
91660	Muscles and tendons - simple	37.03	132.78	4
91662	- radical, e.g., muscle slide	46.29	306.21	5

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
ELBOW AND FOREARM (Cont'd)				
Reduction - Dislocations				
91670	Elbow joint - closed reduction		82.39	4
91672	- open reduction, acute	27.77	245.44	4
91674	- repair chronic, recurrent	27.77	369.45	4
91676	Radial head - closed reduction		38.50	4
91678	- open reduction - acute	27.77	187.84	4
91680	- recurrent	27.77	221.24	6
91682	- late	37.03	347.72	6
Reduction - Fractures				
Epicondyle				
91690	- no reduction		67.75	
91692	- closed reduction	27.77	126.25	4
91694	- open reduction	37.03	214.45	4
91695	- extensive debridement of compound fracture add		107.23	
Transcondylar/condylar				
91696	- no reduction		67.75	
91698	- closed reduction	27.77	200.91	4
91700	- closed reduction with traction	27.77	312.70	4
91702	- open reduction	37.03	497.85	4
91703	- extensive debridement of compound fracture..... add		187.90	
Olecranon				
91704	- no reduction, rigid immobilization		126.25	4
91706	- closed reduction	27.77	129.00	4
91708	- open reduction	37.03	262.28	4
91709	- extensive debridement of compound fracture add		112.28	
Radius and ulnar shaft				
91710	- no reduction, rigid immobilization		67.75	
91712	- closed reduction	27.77	148.50	4
91714	- open reduction	37.03	494.15	4
91715	- extensive debridement of compound fracture add		184.20	
Radius and ulna-Monteggia				
91716	- no reduction, rigid immobilization		67.75	
91718	- closed reduction		144.80	4
91720	- open reduction of ulna plus closed reduction radial head	27.77	342.25	4
91721	- extensive debridement of compound fracture add		121.13	
Radius or ulna				
91722	- no reduction, rigid immobilization		81.30	
91724	- closed reduction	27.77	117.85	4
91726	- open reduction	37.03	446.95	4
91727	- extensive debridement of compound fracture add		137.00	
Radius-distal, Colles', Smith's, Barton's etc.				
91728	- no reduction, rigid immobilization		67.75	
91730	- closed reduction	27.77	154.00	4
91732	- open reduction	37.03	477.28	4
91733	- extensive debridement of compound fracture add		227.00	
91734	Osteochondral - open reduction	37.03	244.58	5

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SHOULDER/ARM/CHEST				
Amputation				
91750	Forequarter	92.57	490.95	15
91752	Shoulder disarticulation	83.31	373.10	9
91754	High humerus	37.03	369.35	5
Arthrodesis				
91760	Shoulder	37.03	468.65	6
Arthroplasty				
91770	Humeral prosthesis	37.03	449.20	6
91772	Total prosthesis	55.54	695.10	10
91774	Revision total arthroplasty shoulder	55.54	942.95	10
91776	Removal prosthesis/no replacement	27.77	397.20	8
91778	Revision of prosthesis add		194.67	
Arthroscopy				
91790	Diagnostic arthroscopy (sole procedure)	27.77	178.86	4
91791	Shoulder arthroscopy setup, includes when rendered debridement, synovectomy, removal of loose body(ies) and/or screw, drilling of defect or microfracture, and/or synovial biopsy	55.54	400.00	10
Notes:				
1. A shoulder procedure listed in the Shoulder section of the Schedule performed arthroscopically is eligible for payment in addition to 91791 if that procedure is not described as a component of 91791 or described by an add-on code to 91791.				
2. Arthroscopic add-on codes listed below are not eligible for payment in addition to 91791 when the service described by the add-on code is a generally accepted component of a procedure described in Note #1.				
91806	Pinning of osteochondral fragment, to 91791 add		251.55	
Note:				
Fracture procedures are not eligible for payment with 91806 for the same fracture.				
91810	Superior labral anterior posterior (SLAP) repair, to 91791 add		336.65	
91812	Arthroscopic capsular release for frozen shoulder, to 91791 add		240.50	
Note:				
Fee code 91810 cannot be billed with fee code 92026.				
Arthrotomy				
91820	Shoulder	27.77	217.42	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SHOULDER/ARM/CHEST (Cont'd)				
Biopsy				
91830	Bones - needle/punch, x-ray control (IOP)		89.70	4
91832	- open (IOP)	37.03	144.80	4
91834	Joint - via arthroscope		10.65	
91836	- open	37.03	223.65	4
91838	Soft tissue - open (IOP)		103.05	4
Incision and Drainage				
91850	Humerus/clavicle/scapula - incision and drainage	37.03	262.60	4
91852	Sequestrectomy	37.03	290.55	4
91854	Saucerization with bone graft	37.03	387.90	4
91856	Bursae/soft tissue		97.35	4
91858	Joint	37.03	223.65	4
Examination and Manipulation				
91870	Manipulation - shoulder/arm/chest under general anaesthetic (IOP)		47.43	4
Excision - Clavicle or Acromion				
91880	Simple (includes ligament)	37.03	211.60	4
91882	Major tumour	46.29	290.55	6
91884	Malignant tumour with reconstruction	46.29	484.35	6
Excision - Humerus				
91890	Head	37.03	299.75	5
91892	Exostosis	37.03	165.20	4
91894	Benign tumour	37.03	289.50	4
91896	Malignant tumour with reconstruction	37.03	681.10	6
Excision - Joint				
91900	Synovectomy and debridement	37.03	425.10	5
91902	Excision of subacromial bursae	27.77	211.60	4
Note:				
Not to be billed with 91908, 91952 or 91954				
91904	Muscle/fascia - simple	27.77	204.75	4
91906	- complex	37.03	484.35	6
91908	Rotator cuff exploration (includes acromioplasty, excision of coraco-acromial ligament and subacromial bursa but excludes simple excision of clavicle)	37.03	206.90	4
Note:				
When 91908 is rendered in association with 91926, 91908 is payable at 85% and 91926 is payable at 100%.				
91910	Acromio/sterno-clavicular meniscectomy	27.77	204.14	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SHOULDER/ARM/CHEST (Cont'd)				
Reconstruction - Pseudoarthrosis and Osteotomy				
91920	Pseudoarthrosis - clavicle	37.03	269.10	4
91922	- humerus	37.03	346.15	4
91924	Osteotomy - humerus	37.03	292.35	4
91926	- clavicle	37.03	211.60	4
91928	- glenoid	37.03	279.35	4
Reconstruction - Muscles/Soft Tissues				
91940	Muscle transplant - pectoralis major	55.54	434.25	6
91942	Muscle/tenon release	46.29	314.60	5
91944	Release - sternomastoid	46.29	296.05	5
91946	Scapulopexy - congenital evaluation	55.54	385.15	6
91948	Trapezius/sternomastoid/transplant	37.03	338.65	4
91950	Tendon repair - biceps	27.77	227.40	4
91952	Rotator cuff repair - simple, end to end or side to side (includes acromioplasty, excision of coraco-acromial ligament and subacromial bursa)	37.03	345.35	5
91954	Rotator cuff repair - complex (includes implantation into bone, and as required, acromioplasty, excision of coraco-acromial ligament, subacromial bursa and excision of distal clavicle)	37.03	498.30	5
Reduction - Fractures				
91960	Tuberosity - no reduction		67.80	
91962	- closed reduction	27.77	117.85	4
91964	- open reduction (without cuff tear)	37.03	340.55	4
91965	- extensive debridement of compound fracture add		145.28	
Neck without dislocation of head				
91966	- no reduction		67.80	
91968	- closed reduction		133.60	4
91970	- open reduction	46.29	377.55	6
91971	- extensive debridement of compound fracture add		163.78	
Neck with dislocation of head				
91972	- no reduction		67.80	
91974	- closed reduction	27.77	183.80	4
91976	- open reduction	46.29	435.15	6
91977	- extensive debridement of compound fracture add		192.58	
91978	Shaft - no reduction		67.80	
91980	- closed reduction	27.77	147.60	4
91982	- open reduction	37.03	423.05	4
91983	- extensive debridement of compound fracture add		161.53	
Clavicle - no reduction				
91984	- closed reduction with anaesthetic	27.77	62.20	4
91986	- open reduction	37.03	450.00	4
91987	- extensive debridement of compound fracture add		150.00	
91988	Scapula - no reduction		67.80	
91990	- closed reduction with anaesthetic	27.77	112.88	4
91992	- open reduction	37.03	242.25	5
91993	- extensive debridement of compound fracture add		121.13	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SHOULDER/ARM/CHEST (Cont'd)				
Reduction - Fractures (Cont'd)				
91994	Sternum - no reduction		65.72	
91996	- closed reduction		115.95	
91998	- open reduction - pleura open	83.31	IC	13
92000	- pleura closed	37.03	IC	4
92001	- extensive debridement of compound fracture add		115.55	
	Ribs - no reduction		VF	
92004	- complicated - pleura open	83.31	IC	13
92006	- pleura closed	37.03	IC	4
Reduction - Dislocations				
Acromio-clavicular/sterno-clavicular				
92010	- no reduction		67.80	
92012	- closed with anaesthetic	37.03	134.55	4
92014	- open reduction	37.03	231.10	4
92016	- open reduction - late	37.03	286.70	4
Glenohumeral joint				
92018	- closed reduction - without anaesthetic		49.20	
92020	- with anaesthetic		111.40	4
92022	- open reduction - early	37.03	323.85	6
92024	- late	37.03	580.90	7
92026	- recurrent	46.29	379.50	5

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SKULL AND MANDIBLE				
Arthroplasty				
92040	Temporo-mandibular joint - unilateral	46.29	336.49	5
Biopsy (IOP)				
92050	Bones - punch, simple		41.81	4
92052	- punch, x-ray control		103.05	4
92054	- open	37.03	204.75	4
Incision and Drainage				
92060	Mandibular sequestrectomy (IOP)	64.80	281.25	7
Excision				
92070	Bone - tumour	IC	IC	IC
92072	Maxilla, with exenteration of orbit and skin graft	37.03	513.04	7
92074	Maxilla advancement	37.03	424.09	8
92076	Mandible	37.03	353.10	7
92078	Mandibular condyle	37.03	266.63	5
92080	Temporo-mandibular menisectomy	27.77	240.82	5
Reconstruction				
92090	Facial paralysis - static slings	37.03	295.94	5
92092	- dynamic slings	37.03	384.40	6
92094	Composite repair for facial paralysis, plication of paralyzed muscles, and resection for paralysis of over active muscles	37.03	491.74	7
92096	- with meloplasty		83.89	
Orthognathic Surgery				
Anterior dento-alveolar osteotomy, maxilla or mandible				
92100	- 1 segment	55.54	775.15	10
92102	- 2 segments	55.54	898.84	10
Posterior dento-alveolar osteotomy, maxilla				
92104	- 1 side	55.54	775.15	10
92106	- both sides, single segment	55.54	898.84	10
92108	- both sides, separate segments	55.54	1,143.95	10
Posterior dento-alveolar osteotomy, mandible				
92110	- 1 side	55.54	775.15	10
92112	- both sides	55.54	1,143.95	10
Total U dento-alveolar osteotomy				
92114	- mandible	55.54	1,183.10	10
92116	- maxilla	55.54	1,267.43	10
92118	Mandibular or maxillary visor osteotomy for alveolar hypoplasia	55.54	1,104.05	10
Genioplasty				
92120	- 1 segment	55.54	246.62	10
92122	- 2 segments, or for laterognathia	55.54	369.67	10
92124	- 3 segments	55.54	492.76	10
Mandibular osteotomies for prognathism				
92126	- subcondylar	27.77	404.73	6
92128	- vertical ramus	55.54	897.98	10
92130	- sagittal split	55.54	897.98	10

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SKULL AND MANDIBLE (Cont'd)				
Orthognathic Surgery (Cont'd)				
Mandible osteotomies for retrognathia, any technique				
92140	- advancement - up to 10 mm	55.54	897.98	10
92142	- 10 to 20 mm	55.54	1,020.48	10
92144	- greater than 20 mm	55.54	1,307.44	10
92146	- for apertognathia or laterognathia add		246.62	
LeFort I advancement				
92148	- in 1 segment	92.57	774.40	20
92150	- in 2 segments add		285.77	
92152	- in 3 segments add		572.51	
LeFort I intrusion				
92154	- in 1 segment	92.57	1,020.48	20
92156	- in 2 segments add		285.77	
92158	- in 3 segments add		572.51	
LeFort I extrusion				
92160	- in 1 segment	92.57	1,267.43	20
92162	- in 2 segments add		285.77	
92164	- in 3 segments add		572.51	
LeFort I cleft palate				
92166	- in 1 segment	92.57	1,469.09	20
92168	- in 2 segments add		246.62	
92170	- in 3 segments add		493.25	
92172	- with SMR		197.52	
92174	- with pharyngoplasty		295.94	
92176	- with closure alveolar fistula with or without bone graft add		369.67	
92178	- with closure hard palate fistula with or without bone graft add		493.25	
92180	Naso-maxillary osteotomy without LeFort I	55.54	774.40	10
92182	LeFort II maxillary osteotomy and advancement	92.57	1,390.90	20
92184	Construction glenoid fossa and zygomatic arch	92.57	1,350.89	20
92186	Construction absent condyle and ascending ramus	55.54	774.40	10
92188	Combined LeFort I and LeFort III osteotomy in hemifacial microsomia	92.57	1,469.09	20
92200	Mandibular condylotomy	37.03	197.31	5
92202	Coronoidotomy	37.03	197.31	5
92204	Coronoidectomy	37.03	295.94	5
Reconstruction mandible with bone grafts and/or plate or prosthesis				
92210	- unilateral - partial	37.03	409.55	10
92212	- complete	37.03	819.15	10
92214	- bilateral - partial	37.03	819.15	10
92216	- complete	37.03	1,023.95	10
Oral vestibuloplasty				
92218	- with secondary epithelization	37.03	197.31	5
92220	- with skin graft	37.03	295.94	5
Temporomandibular ankylosis				
92222	- excision bone or fibrous block	27.77	444.31	6
92224	- with insertion of prosthetic device or muscle flap	37.03	493.25	8
92226	- with construction of condyle and ascending ramus	37.03	641.67	10

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SKULL AND MANDIBLE (Cont'd)				
Orthognathic Surgery (Cont'd)				
Onlay bone grafts to face when not part of standard osteotomy for reconstruction				
92230	- mandible - unilateral		394.80	
92232	- bilateral		507.45	
92234	- maxilla - unilateral		394.80	
92236	- bilateral		507.45	
92238	- zygoma - unilateral		295.94	
92240	- bilateral		394.62	
92242	- temporal - unilateral		394.62	
92244	- bilateral		493.25	
92246	- frontal - unilateral		394.62	
92248	- bilateral		493.25	
Application of dental arch bars, or splint, for facial osteotomy (IOP)				
92260	- 1 arch bar	37.03	128.10	4
92262	- 2 arch bars	37.03	197.31	4
92264	Interdental wiring for temporomandibular joint disorder	27.77	148.00	5
92266	Removal intermaxillary fixation devices under general anaesthesia- as sole procedure		102.35	4
Orbito-cranial Surgery				
Bilateral periorbital correction Treacher-Collins Syndrome				
92280	- with or without bone grafts (extra-cranial)	92.57	1,604.07	20
92282	- with skull and muscle transpositions (includes skull reconstruction) (intracranial)	92.57	2,044.08	25
92284	Pericranial flap to orbit or face - unilateral		307.15	4
92286	- bilateral		394.62	4
- when in conjunction with coronal approach for main operation				
92288	- unilateral		172.41	
92290	- bilateral		285.77	
92292	LeFort III total maxillary advancement	111.08	1,962.02	25
92294	LeFort III and subcranial hypertelorism correction	111.08	2,494.95	25
92296	LeFort III and LeFort I maxillary advancement	111.08	2,248.87	25
92298	LeFort II, subcranial hypertelorism correction, LeFort I maxillary advancement Upper LeFort III advancement without occlusal change	111.08	2,820.84	25
92300	- unilateral	55.54	897.98	10
92302	- bilateral	111.08	1,390.90	25
Forehead advancement (bone grafts not included)				
92304	- unilateral	111.08	1,143.95	25
92306	- bilateral	111.08	1,390.90	25
92308	Cranial vault reshaping - anterior or posterior half	92.57	1,469.09	20
92310	Total cranial vault reshaping	111.08	2,001.97	25
92320	Medial transnasal canthopexy - unilateral	27.77	398.71	6
92322	- when done in conjunction with another procedure		148.00	
92324	Lateral canthoplasty - unilateral	27.77	197.31	6
92326	- when done in conjunction with another procedure		97.66	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SKULL AND MANDIBLE (Cont'd)				
Orbito-cranial Surgery (Cont'd)				
Hypertelorism correction				
92328	- intracranial approach	111.08	2,248.87	25
92330	- subcranial U osteotomies	111.08	1,878.55	25
92332	- medial orbital wall osteotomies	92.57	1,183.10	20
92334	- medial and lateral orbital wall osteotomies	92.57	1,553.42	20
92336	Orbital dystopia - intracranial approach	111.08	1,878.55	25
92338	- extracranial approach	92.57	1,430.91	20
Late correction traumatic enophthalmos – total periorbital stripping and bone grafts				
92340	- intracranial	111.08	1,923.83	25
92342	- extracranial	92.57	1,390.90	20
Harvesting of bone graft when not included				
92350	- iliac bone graft		96.15	
92352	- rib graft - 1 rib		148.00	
92354	- each subsequent rib		74.00	
92356	- costochondral or chondral graft - 1 rib		221.99	
92358	- subsequent rib		148.00	
92360	- split cranial graft		197.31	
Surgery for Correction of Down's Syndrome Facial Stigmata				
Augmentation of zygoma (bilateral)				
92370	- with prosthetic implant		173.86	
92372	- with autogenous bone or cartilage		217.48	
Augmentation of chin				
92380	- with prosthetic implant		144.98	
92382	- with autogenous bone or cartilage		178.86	
92384	Horizontal resection, red lower lip		173.86	
Reduction – Fractures				
Orbit				
Open reduction rim/wall fracture				
92400	- zygomatic fracture dislocation	37.03	594.70	6
92402	- with miniplate(s) per major fracture line		99.85	
92406	- blowout fracture or floor	37.03	667.00	6
92408	- secondary repair by combined or orbital approach	46.29	459.10	6
Nasal bones (including septum)				
92410	- closed reduction		102.35	4
92412	- open reduction		316.35	5
92414	- with miniplate(s) per major fracture line		63.95	
92415	- extensive debridement of compound fracture		158.18	
92426	Middle 1/3 facial	46.29	451.12	8
92428	Cranial-facial separation	46.29	522.72	10

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SKULL AND MANDIBLE (Cont'd)				
Reduction - Fractures (Cont'd)				
Mandible				
92430	- closed reduction (includes wiring of teeth)		350.00	5
	- open reduction (may include wiring of teeth)			
92432	- 1 side	37.03	575.00	5
92434	- with miniplate(s) per major fracture line add		104.00	
92436	- complicated	IC	IC	IC
92438	- removal of interdental wire			5
92439	- extensive debridement of compound fracture add		287.50	
Maxilla				
92440	- closed reduction and dental wiring		246.62	
92442	- open reduction - simple	37.03	256.40	5
92444	- with wiring and local fixation	46.29	685.20	6
92446	- with miniplate(s) per major fracture line add		107.20	
92447	- extensive debridement of compound fracture add		342.60	
Temporo-mandibular joint				
92450	- closed reduction		51.65	4
92452	- open reduction	46.29	256.40	5

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SPINE				
Arthrodesis				
92470	Anterior or posterior fusion of 1 level	64.80	459.00	10
92472	Fusion of C1-2	74.06	621.16	10
92474	Each additional level (max. of 2) add		95.55	
Fusion with other procedure(s) – by same surgeon				
92476	- 1 level add		272.11	
92478	- multiple levels add		346.46	
92480	- anterior cervical interbody fusion, per level add		90.92	
Fusion by different surgeon				
92482	- 1 level add		347.99	
92484	- multiple levels add		409.29	
92486	- anterior cervical interbody fusion, per level add		134.51	
92488	Repeat fusion add		225.74	
92490	With instrumentation add		154.49	
Biopsy				
92500	Bone - needle (IOP)	37.03	162.03	4
92502	- open - posterior approach	37.03	271.12	7
92504	- anterior approach	55.54	346.76	8
92506	Soft tissue - open (IOP)		108.73	4
Decompression - Anterior, Anterolateral or Posterolateral				
92510	Simple anterior cervical discectomy	74.06	826.20	10
92512	Simple anterior lumbar discectomy	55.54	1,101.60	10
92514	Anterior cervical spinal cord or nerve root decompression, including removal of disc or vertebral body, single disc level	74.06	676.21	10
92516	Anterior decompression with instrumentation	83.31	1,618.96	13
92518	Anterolateral or posterolateral decompression, lumbar or thoracic spine, single disc level	83.31	1,210.41	13
92520	- each additional disc level decompressed – to 92510, 92512, 92514, 92518 add		291.90	
Decompression – Posterior				
92540	Cervical hemilaminectomy for disc disease, with or without foraminotomy	55.54	904.23	10
92542	Lumbar hemilaminectomy for disc disease including removal of soft disc or osteophyte	55.54	800.70	8
92544	- multiple levels, to 92540, 92542 add		229.50	
92546	- bilateral, to 92540, 92542 add		230.50	
92548	Posterior laminectomy 1 or 2 levels, cervical, thoracic, lumbar	55.54	776.00	9

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SPINE (Cont'd)				
Decompression – Posterior (Cont'd)				
92550	Repeat posterior exploration or reopening of posterior exploration, more than six months after original procedure, includes foraminotomy, discectomy or neurolysis	74.06	729.27	10
92552	- laminectomy extending over 3 or more laminae, to 92548, 92550		175.02	
92554	- foraminotomy, to 92542, 92548 and 92550 per foramen decompressed		100.00	
92556	- opening of dura (associated with any decompressive procedure)		200.00	
92558	- spinal duroplasty (applies to any spinal procedure)		300.00	
Incision and Drainage (Osteomyelitis)				
92570	Bone - incision and drainage only	37.03	337.55	4
Sequestrectomy				
92572	- anterior	64.80	704.28	10
92574	- posterior	37.03	401.99	4
Saucerization with bone grafting				
92576	- anterior	55.54	867.43	10
92578	- posterior	37.03	490.30	5
92580	Soft tissue		118.50	
Examination/Manipulation				
92590	Manipulation - spine - under sedation/anaesthesia (IOP)		43.36	4
Excision – Bone				
92600	Spinous process	37.03	271.37	4
92602	Lamina or transverse process	55.54	433.16	8
92604	Part of body or pedicle	55.54	649.99	8
92606	Total body (includes replacement)	83.31	1,082.65	13
Excision - Muscle/Soft Tissue				
92610	Tumours - simple	55.54	239.57	8
92612	- radical resection	83.31	591.06	13
Reconstruction - Osteotomy (includes fixation/fusion)				
92620	Anterior - via chest	83.31	811.28	13
92622	- via abdomen	83.31	867.43	9
92624	- via chest and abdomen	83.31	976.52	13
92626	Posterior	83.31	767.61	9
92628	- with rib or transverse release		137.92	
92630	Circumferential	83.31	1,300.22	9
92632	Cervical	92.57	1,138.92	12

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SPINE (Cont'd)				
Instrumentation - Deformities				
	Anterior - includes fusion/disectomy			
92640	- via chest or abdomen	83.31	1,422.79	17
92642	- via chest and abdomen	83.31	1,569.54	17
92644	Posterior (Harrington) – with or without fusion (92648, 92650, 92652 may be billed as appropriate)	74.06	863.22	12
92646	Readjustment of instrumentation		162.03	4
92648	- Harrington instrumentation to sacrum or pelvis (payable in addition to 92644 or 92646 only)		86.71	
92650	- Harrington instrumentation, for each level over 6 (payable in addition to 92644 or 92646 only)		21.03	
92652	- with posterior osteotomy (payable with 92650 only)		164.63	
92654	Segmental procedure - with fusion	74.06	1,356.64	12
92656	- segmental instrumentation to pelvis, add to 92654		172.42	
92658	- segmental instrumentation, for each level over 6		91.80	
92660	Removal of - anterior instrumentation	74.06	324.06	8
92662	- posterior instrumentation	74.06	292.89	8
	Revision of entire instrumentation			
92664	- with fusion	74.06	1,354.39	12
92666	- without fusion	74.06	1,082.65	12
92682	Removal of electrodes	74.06	285.11	8
92684	Muscle stripping spine prior to surgery	55.54	216.02	8
92686	Halo traction prior to surgery (complete care)	27.77	325.68	4
Note:				
92684 and 92686 allow full benefit if followed by surgery for correction of scoliosis in same hospitalization.				
	Anterior release including Halo traction			
92690	- via chest or abdomen	83.31	610.77	13
92692	- via chest and abdomen	83.31	758.34	13
92694	Localizer cast		148.55	4
Reduction – Fractures or Fracture Dislocations				
	Fracture of spine without procedure		VF	
92702	Skull calipers (IOP)		56.04	
92704	Halo traction (IOP)		89.80	
92706	Reapplication of Halo traction (IOP)		56.04	
92708	- counter traction pins or vest		119.98	
92710	Closed reduction	46.29	226.48	5

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SPINE (Cont'd)				
Reduction – Fractures or Fracture Dislocations (Cont'd)				
Open reduction				
92712	- posterior approach	46.29	918.00	10
92714	- anterior approach	64.80	918.00	10
92716	- with spinal cord injury (when total care by operating surgeon)		255.00	
92718	- with irrigation, including opening of dura, to fractures when combined with decompressive procedures		347.99	
	- fusion by same surgeon			
92720	- 1 level		272.11	
92722	- 2 or more levels		346.46	
	- fusion by different surgeon			
92724	- 1 level		347.99	
92726	- 2 or more levels		409.29	
92728	-with instrumentation		154.49	
92729	-extensive debridement of compound fracture		204.65	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
PELVIS AND HIP				
Amputation				
92740	Hemipelvectomy - hindquarter	92.57	796.20	15
92742	Hip disarticulation	92.57	476.85	10
Arthrodesis				
92750	Sacro-iliac joint	46.29	395.25	5
92752	Symphysis pubis	46.29	387.00	6
92754	Hip	46.29	703.45	8
Arthroplasty				
92760	Unipolar	55.54	577.48	8
92762	Bipolar	74.06	679.21	8
92764	Total hip replacement with take down of fusion	74.06	972.90	10
92766	Revision total arthroplasty hip	74.06	1,422.88	10
92768	Total hip arthroplasty	74.06	825.59	8
92770	- bone graft to acetabulum		101.25	
92772	- acetabular reconstruction (extensive, including bone grafts)		194.00	
92774	Reattachment of greater trochanter (late)		290.55	8
92776	Removal only - non-cemented	27.77	447.30	8
92778	- cemented	27.77	557.75	8
Arthroscopy				
92790	Hip joint, sole procedure (IOP)		178.86	4
92792	- preceding surgery, same surgeon		134.26	
Arthrotomy				
92800	Sacro-iliac joint	46.29	282.22	6
92802	Hip - with removal of loose body	46.29	293.52	6
92810	Hip - infant or child, under general anaesthesia	27.77	61.84	4
Biopsy				
92820	Bone - punch needle (IOP)		89.70	
92822	- under general anaesthetic (IOP)		72.35	5
92824	- open (IOP)	37.03	144.80	4
92826	Joint - via arthroscope		10.65	
92828	- open	46.29	301.60	6
92830	Soft tissue - open		97.35	4
Denervation/Decompression				
92840	Decompression of lateral femoral cutaneous nerve	37.03	146.33	4
92842	Exploration and/or decompression of sciatic nerve	55.54	410.11	6
92844	Exploration and/or decompression and/or transposition and/or neurolysis of major nerve	37.03	243.93	4
92846	Denervation of hip	37.03	387.00	5

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
PELVIS AND HIP (Cont'd)				
Incision and Drainage				
92850	Bone, incision and drainage	27.77	290.55	4
92852	Sequestrectomy.....	37.03	379.50	4
92854	Saucerization and bone graft	37.03	627.30	5
92856	Bursae/soft tissue (IOP)		97.35	4
92858	Joint	46.29	301.60	6
Examination/Manipulation				
92870	Manipulation - pelvis and hip - under general anaesthetic (IOP)		37.70	4
Excision – Bone				
92880	Simple cyst, etc.	37.03	338.75	4
92882	Major resection tumour	37.03	629.65	6
92884	Radical resection tumour	74.06	1,007.35	8
92886	Coccyx	37.03	208.80	4
92888	Head and neck, femur	37.03	452.90	6
Excision – Muscle				
92900	Simple	27.77	193.00	4
92902	Complex	37.03	484.35	6
92904	Myositis	37.03	289.50	5
Excision – Joint				
92910	Synovectomy/debridement	46.29	470.50	5
Excision – Bursae				
92920	GT trochanteric/ischial	27.77	201.40	4
Reconstruction – Pseudoarthrosis				
92930	Pelvis.....	74.06	580.90	10
92932	Hip	55.54	477.90	6
Reconstruction – Osteotomy				
92940	Pelvis - infant		399.00	8
92942	- other	74.06	580.90	8
92944	Hip	46.29	539.15	7
Reconstruction - Muscle/Tendon				
92950	Muscle release	46.29	314.60	5
92952	Closed adductors - tenotomy (IOP)		49.20	4
92954	Open adductors - tenotomy (IOP)		97.35	4
92956	Iliopsoas - tenotomy	46.29	266.35	5
Reconstruction - Tendon Transfer				
92970	Iliopsoas	46.29	520.60	6
92972	Abductor	46.29	339.65	6

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
PELVIS AND HIP (Cont'd)				
Reduction – Fractures				
	Coccyx - no reduction		VF	
92982	- excision	37.03	208.80	4
	Pelvic ring - no reduction		VF	
92986	- closed reduction	27.77	442.45	4
92988	- open reduction	55.54	680.30	8
92989	- extensive debridement of compound fracture add		340.15	
	Sacrum - no reduction		VF	
	Femoral neck trochanteric, subtrochanteric			
	- no reduction		VF	
92994	- closed reduction/traction	27.77	426.90	4
92996	- open reduction - pin only	55.54	432.34	8
92998	- pin and plate	55.54	589.08	8
93000	- primary prosthesis	55.54	586.86	8
93002	- delayed/staged graft	55.54	289.50	8
93003	- extensive debridement of compound fracture add		249.48	
	Slipped epiphysis			
93004	- closed reduction/traction	55.54	387.00	8
93006	- closed reduction/internal fixation	55.54	387.00	8
93008	- open reduction/fixation	55.54	580.90	8
93009	- extensive debridement of compound fracture add		290.45	
Reduction – Dislocations				
	Acetabulum - no reduction		VF	
93022	- open reduction - lips	64.80	612.45	8
93024	- 1 pillar	37.03	967.90	10
93026	- 2 pillars	74.06	1,451.45	12
93028	Hip - closed reduction		268.25	4
93030	- open reduction	64.80	406.45	7
93032	- late	64.80	774.90	10
93033	- extensive debridement of compound fracture add		203.23	
	Sacro-iliac			
93034	- closed, traction, spica, etc.		428.50	5
93036	- open reduction	46.29	593.00	5
93037	- extensive debridement of compound fracture add		296.50	
	Sacro-coccygeal			
	- closed reduction		VF	
93040	- open, removal of coccyx	46.29	193.00	5
93041	- extensive debridement of compound fracture add		96.50	
	Congenital hip			
93042	- closed reduction (includes tenotomy and cast)		190.20	4
93044	- repeat (includes cast)		131.80	4
93046	- open reduction (includes tenotomy and arthrotomy)	64.80	472.35	7
93048	Application Pavlik Harness or CDH splint		24.10	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
FEMUR				
Amputation				
93060	Gritti-Stokes or Callander	46.29	379.64	5
93062	Through femur	46.29	348.30	5
Biopsy (IOP)				
93070	Bone - core, punch		48.50	4
93072	- x-ray control/general anaesthetic		120.70	4
93074	- open	37.03	193.00	4
93076	Soft tissue - open		97.35	4
93078	Injection into bone cysts		117.00	
Incision and Drainage (Osteomyelitis)				
93090	Incision and drainage, bone	27.77	325.75	4
93092	Sequestrectomy	27.77	395.25	4
93094	Saucerization and graft	46.29	619.90	6
93096	Soft tissue		103.05	4
Excision – Bone				
93100	Simple cyst/exostosis	37.03	225.50	4
93102	Bone tumour - simple	37.03	629.65	6
93104	- with reconstruction/graft	74.06	1,007.35	8
Excision – Muscle				
93110	Simple	27.77	193.00	4
93112	Complex	37.03	484.35	6
Reconstruction – Pseudoarthrosis				
93114	Reconstruction - pseudoarthrosis	55.54	477.90	6
93116	- Intramedullary nail with distal and proximal locking screws - femur, to 93114 or 93208		108.75	
Reconstruction – Fascial				
93120	Simple	27.77	193.00	4
93122	Complex with or without synthetic graft or rotation flap	55.54	402.75	5
Reconstruction – Osteotomy				
93130	Femoral shaft	37.03	532.65	5
93132	Supracondylar	55.54	387.00	6
Reconstruction - Leg Length Operations				
93140	Femoral shortening - all types	37.03	480.70	4
93142	Femoral lengthening - all types	37.03	541.95	4
93144	Femoral epiphysiodesis	37.03	301.60	5
93146	Tibial and femoral epiphysiodesis	37.03	426.90	5
93148	Femoral stapling	37.03	313.65	4
93150	Tibial and femoral stapling	37.03	387.00	5

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
FEMUR (Cont'd)				
Reconstruction - Muscle/Tendons				
93160	Quadriceps repair - simple	27.77	413.70	4
93162	- reconstructive	27.77	387.00	4
93164	Quadricepsplasty - all types	37.03	381.40	5
93166	Ilio-tibial band	27.77	191.10	4
93168	Closed release of ilio-tibial band (IOP)		49.20	4
93170	Tenotomy of hamstrings - single	27.77	168.85	4
93172	- multiple	27.77	193.00	4
	Lengthening of hamstrings			
93174	- single	27.77	223.65	4
93176	- each additional		77.05	
	Tendon or muscle transfer			
93178	- single	27.77	307.15	5
93180	- each additional (max. of 1)		87.20	
93182	Excision of myositis	37.03	289.50	5
Reduction - Fractures				
	Femoral shaft/supracondylar			
	- no reduction, cast		VF	
	- closed reduction - traction			
93202	- infant or child	27.77	258.00	4
93204	- adult or adolescent	27.77	407.35	4
93206	- closed reduction, cast	27.77	258.90	4
93208	- open reduction	55.54	543.80	8
93209	- extensive debridement of compound fracture, infant or child		246.90	
93210	- extensive debridement of compound fracture, adult or adolescent		246.90	
 add			

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
KNEE				
Amputation				
93220	Through knee - disarticulation	46.29	305.25	5
Arthrodesis				
93230	Knee	27.77	402.75	5
Arthroplasty				
93240	Patellar arthroplasty	27.77	241.60	5
93242	Hemi-arthroplasty - single component	55.54	351.70	6
93244	- double component	55.54	619.90	6
93246	Total replacement/both compartments	74.06	619.90	8
93248	Total knee replacement with take down of fusion	74.06	838.00	8
93250	Revision total arthroplasty knee	74.06	1,223.54	8
93252	With associated patellar replacement or patelloplasty		94.60	
93254	Removal of hemi-arthroplasty - without replacement	37.03	242.25	5
93256	Removal of total arthroplasty - without replacement	37.03	368.40	5
93258	Revision of arthroplasty		169.94	
Arthroscopy				
93270	Diagnostic arthroscopy (sole procedure)		192.37	4
93272	Synovial biopsy		42.81	
93274	Trimming of plica, tissue, meniscus		62.27	
93276	Removal of loose body, screw		187.84	
93278	Resection of plica		86.42	
93280	Lateral release		161.45	
93282	Synovectomy - anterior - 1 compartment		127.99	
93284	- anterior - more than 1 compartment		256.41	
93286	- total, anterior and posterior		469.58	
93288	Drilling of defect, includes removal of loose body		251.55	
93290	Pinning of osteochondral fragment		251.55	
93292	Debridement - 1 compartment		284.29	
93294	- more than 1 compartment		380.45	
93296	Microfracture and/or abrasion arthroplasty, for osteoarthritic cartilage deficiency (includes removal of loose body(ies))		281.79	
93298	Meniscectomy		337.70	
93300	Repair medial or lateral meniscus		320.17	
93302	Arthroscopy in association with surgery including 93272 to 93300 – same surgeon		144.40	
Arthrotomy				
93320	Knee - with or without removal of loose body	27.77	202.31	4
93322	Osteochondritis dissecans with drilling and/or internal fixation	27.77	267.25	4
Biopsy				
93330	Bone/joint - needle (IOP)		120.70	4
93332	- open (IOP)	37.03	193.00	4
93334	- via arthroscope		10.65	
93336	Soft tissue – open (IOP)		97.35	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
KNEE (Cont'd)				
Denervation/Decompression				
93340	Denervation - of knee	27.77	258.00	4
93342	- of gastrocnemius	37.03	256.15	4
Incision and Drainage				
93350	Soft tissue (IOP)		97.35	4
93352	Joint	27.77	193.00	4
Examination/Manipulation				
93360	Manipulation - knee - under general anaesthetic (IOP)		23.02	4
Excision				
93370	Baker's cyst - simple	27.77	148.50	4
93372	- extensive	37.03	264.50	6
93374	Cysts of meniscus	27.77	126.25	4
93376	Meniscectomy	27.77	241.30	4
93378	Debridement of joint without synovectomy	27.77	290.55	4
93380	Synovectomy	27.77	430.65	5
93382	Pre-patellar bursae	27.77	149.45	4
93384	Patella - to include fascial repair	27.77	276.55	4
93386	Exostosis/cyst patella	27.77	126.25	4
Reconstruction – Meniscus				
93390	Suturing of medial or lateral meniscus	27.77	242.25	5
Reconstruction - Muscles/Tendons				
93400	Tenoplasty - 1	27.77	144.80	4
93402	- each additional		77.05	
Suture of patellar or quadriceps tendon				
93404	- early	27.77	227.40	4
93406	- late	27.77	387.00	4
Transplant of tendon				
93408	- single	27.77	307.15	5
93410	- each additional (max. of 1)		87.20	
93416	Tenotomy - open - 1	27.77	232.00	4
93418	- multiple	27.77	253.30	4
93420	Release patellar retinaculum	46.29	161.45	5
Reconstruction - Ligaments				
93430	Simple - 1	27.77	361.95	4
93432	Extensive/multiple (including synthetics) includes when rendered preparation of intracondylar notch	37.03	517.85	6
93434	Synthetic anterior/posterior cruciate	55.54	480.02	6
93436	Removal of synthetics	37.03	213.45	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
KNEE (Cont'd)				
Reduction - Fractures				
93450	Patella - no reduction		67.75	
93452	- open reduction/excision with/without repair	37.03	275.65	4
93453	- extensive debridement of compound fracture add		137.83	
93454	Osteochondral fracture - open reduction	37.03	392.40	5
Reduction – Dislocations				
93460	Knee - closed reduction		207.90	4
93462	- open reduction	46.29	309.00	5
Patella				
- closed reduction				
93464	- without anaesthetic		62.20	
93466	- with anaesthetic		97.35	4
93468	- open reduction - early		290.55	5
93470	- late	37.03	484.35	6
93472	- repair recurrent dislocation, includes inspection of joint	37.03	393.40	5
93474	Congenital dislocation - knee (open)	37.03	484.35	6

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
FIBULA AND TIBIA				
Amputation				
93490	Tibia/fibula	46.29	348.30	5
Biopsy				
93500	Bone - simple - punch		120.70	4
93502	- open	37.03	193.00	4
93504	Soft tissue - open		97.35	4
93506	Injection into bone cysts		117.00	
Decompression/Denervation				
93510	Decompression of fascial compartments	27.77	320.20	4
93512	Secondary closure		97.35	
93514	Catheter insertion (IOP)		49.20	
	Monitoring of pressure monitoring device		VF	
93518	Decompression of posterior tibial or common peroneal nerve	37.03	165.20	4
Incision and Drainage (Osteomyelitis)				
93530	Incision and drainage, bone	27.77	308.10	4
93532	Sequestrectomy	27.77	329.40	4
93534	Saucerization and bone grafting	27.77	411.20	4
93536	Soft tissue		97.35	4
Excision				
93540	Exostosis/cyst	27.77	201.40	4
93542	Fibular head	27.77	193.00	4
93544	Tumour - simple	37.03	289.50	4
93546	- extensive with repair	46.29	659.20	6
93548	Excision bone ridge to include interpositional materials	46.29	385.15	6
93550	Muscle/soft tissue - simple	27.77	193.00	4
93552	- complex	37.03	513.96	6
Reconstruction – Pseudoarthrosis				
93560	Tibia/fibula	37.03	348.00	5
93562	By-pass fibular graft	37.03	341.45	6
93564	Congenital pseudoarthrosis	37.03	484.35	6
93566	- Intramedullary nail with distal and proximal locking screws – tibia, to 93560 or 93564 or 93614 or 93616 or 93618		add 81.55	
Reconstruction – Osteotomy				
93570	Tibia and fibula	27.77	376.80	4
93572	Repair recurrent dislocation, includes inspection of the joint	37.03	393.40	6
Reconstruction - Leg Length Operations				
93580	Tibial lengthening	37.03	470.50	4
93582	Tibial shortening	37.03	387.00	4
93584	Tibial and femoral epiphysiodesis	37.03	426.90	5
93586	Tibial epiphysiodesis	37.03	322.05	5
93588	Tibial stapling - 1 side	37.03	193.00	4
93590	- both sides	37.03	242.25	4
93592	Tibial and femoral stapling	37.03	387.00	5

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
FIBULA AND TIBIA (Cont'd)				
Reduction - Fractures				
Tibia with or without fibula				
93610	- no reduction, rigid immobilization		115.95	
93612	- closed reduction	27.77	180.05	4
93614	- open reduction - shaft	37.03	457.25	5
93616	- medial or lateral tibial plateau	37.03	444.22	5
93618	- both tibial plateaus, same knee	37.03	641.34	5
93619	- extensive debridement of compound fracture add		203.63	
93620	Fibula - no reduction, rigid immobilization		67.75	
93622	- closed reduction		101.25	4
93624	- open reduction	37.03	230.20	4
93625	- extensive debridement of compound fracture add		115.10	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
FOOT AND ANKLE				
Amputation				
93640	Metatarsal/phalanx disarticulation	37.03	155.90	4
93642	- each additional		47.30	
93644	Ray (single)	37.03	234.38	4
93646	Symes	46.29	302.70	5
93648	Transmetatarsal/transtarsal	37.03	270.22	4
93650	Terminal Symes	46.29	200.68	5
Arthrodesis				
93660	Ankle	27.77	500.00	4
93662	Interphalangeal	27.77	154.02	4
93664	- each additional		41.55	
93666	Metatarsophalangeal	27.77	262.00	4
93668	Midtarsal/subtarsal	27.77	450.00	4
93670	Triple	27.77	488.33	5
93672	Pan-talar - 1 stage	27.77	626.45	6
Arthroplasty				
93680	Ankle - total replacement	55.54	1,177.50	6
93682	Revision total arthroplasty ankle	55.54	1,589.63	6
93684	Removal of prosthesis without replacement	27.77	193.00	6
Metatarsophalangeal interposition				
93686	- single	27.77	144.80	5
93688	- each additional		38.00	
93690	Metatarsophalangeal	27.77	289.50	5
93700	- multiple	27.77	387.00	6
93702	Removal - prosthesis without replacement	27.77	144.80	4
93704	Revision of arthroplasty		124.76	
Arthroscopy				
93710	Diagnostic arthroscopy (sole procedure)	27.77	178.86	4
93711	Ankle arthroscopy setup, includes when rendered debridement, synovectomy, removal of loose body(ies) and/or screw, drilling of defect or microfracture and/or synovial biopsy	55.54	400.00	7

Notes:

1. An ankle procedure listed in the Foot and Ankle section of the Schedule performed arthroscopically is eligible for payment in addition to 93711 if that procedure is not described as a component of 93711 or described by an add-on code to 93711.
2. Arthroscopic add-on codes listed below are not eligible for payment in addition to 93711 when the service described by the add-on code is a generally accepted component of a procedure described in Note #1.

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
FOOT AND ANKLE (Cont'd)				
Arthroscopy (Cont'd)				
93725	Arthroscopy of subtalar and/or intratarsal joint(s), through separate portals, to 93711		192.00	
93726	Pinning of osteochondral fragment, to 93711		251.55	
Note: Fracture procedures are not eligible for payment with 93726 for the same fracture.				
93730	Osteochondroplasty (extensive bone and arthrofibrotic tissue removal requiring a minimum of 2 hours to resect), to 93711		500.00	
93732	Synovectomy for inflammatory arthritis requiring a minimum of 90 minutes to resect, to 93711		326.55	
93734	Excision of Os Trigonum (sole procedure)	55.54	230.00	7
Notes:				
1. Only one of 93730 or 93732 is eligible for payment same patient same day.				
2. Fee code 93711 is not eligible for payment in addition to 93734.				
Arthrotomy				
93740	Ankle - removal of loose body, etc.	27.77	162.09	4
93742	- with osteotomy of malleolus		117.85	
93744	Mid tarsals	27.77	144.80	4
93746	Metatarsal/phalangeal	27.77	144.80	4
Biopsy				
93760	Bone - needle - punch (IOP)		48.50	4
93762	- punch - under general anaesthetic		120.70	4
93764	- open	37.03	193.00	4
93766	Joint - via arthroscope		10.65	
93768	- open		168.00	4
93770	Soft tissue - open (IOP)		97.35	4
Incision and Drainage				
93780	Incision and drainage - bone	27.77	227.40	4
93782	Sequestrectomy	37.03	193.00	4
93784	Saucerization and bone graft	37.03	387.00	4
93786	Bursae (IOP)		97.35	4
93788	Joints	27.77	176.67	4
93790	Soft tissue (IOP)		97.35	4
Examination/Manipulation (IOP)				
93800	Manipulation - foot and ankle - under general anaesthetic		23.02	4
Club foot, etc. - manipulation and cast/strapping				
93810	- without anaesthetic		19.45	
93812	- with anaesthetic		39.00	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
FOOT AND ANKLE (Cont'd)				
Excision – Bone				
93820	Phalanx	27.77	127.15	4
93822	Metatarsal head	27.77	175.45	4
93824	- each additional		41.70	add
93826	Accessory navicular (scaphoid)	27.77	155.90	4
93828	Bunion/bunionette	27.77	150.30	4
93830	Calcaneal spur	27.77	135.52	4
93832	Exostosis (dorsal, subungual)	27.77	100.15	4
93834	Os calcis, talus	27.77	283.95	4
93836	Sesamoid, 1 or both	27.77	142.00	4
93838	Tarsal bar	27.77	230.20	4
93840	Tumour (foot)	27.77	241.30	4
Excision – Joint				
93850	Ankle synovectomy	27.77	273.75	4
	Metatarsophalangeal synovectomy			
93852	- 1	27.77	226.40	4
93854	- 2 or more	27.77	339.65	4
Excision - Soft Tissue				
93860	Ganglion - simple or complex	27.77	177.80	4
93862	Bursa	27.77	149.45	4
93864	Fascia (Dupuytren's) - partial or complete	27.77	322.66	4
93866	Muscle - simple	27.77	193.00	4
93868	- complex	37.03	484.35	6
Reconstruction – Pseudoarthrosis				
93880	Malleoli	27.77	296.05	4
93882	Tarsals/metatarsals/phalanx	27.77	260.75	4
Reconstruction – Osteotomy				
93890	Os calcis	27.77	297.85	4
93892	Metatarsals and phalanx	27.77	144.80	4
93894	- each additional		41.70	add
93896	Midtarsal/tarsal	27.77	242.25	4
93898	Shortening metatarsal - 1	37.03	225.50	4
93900	- 2 or more	37.03	272.80	4
Reconstruction – Forefoot				
93910	Claw and hammer toe	27.77	151.25	4
93912	- each additional hammer toe		41.70	add
93914	Hallux Valgus - e.g., Mayo, Keller	27.77	217.15	4
93916	- e.g., Joplin, McBride	27.77	297.37	4
93918	Major forefoot reconstruction, must include the first MP joint and a minimum of 2 other MP joints	27.77	459.45	5
93920	Overlapping 5 th toe	27.77	136.35	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
FOOT AND ANKLE (Cont'd)				
Reconstruction - Club Foot				
93930	Posterior or medial release	37.03	312.70	4
93932	Posteromedial release, lateral shortening, tendon transfers and fusion	37.03	371.20	4
93936	Plantar fascia release	27.77	165.20	4
Reconstruction - Ligaments				
93950	Ankle - 1	27.77	301.60	4
93952	- extensive/multiple	27.77	511.45	4
Reconstruction - Tendons				
93960	Exploration - tendon sheath	27.77	126.25	4
93962	Tenolysis - extensive release - 1	27.77	202.25	4
93964	- each additional digit (max. of 2)		87.20	add
93966	Tendon transfer foot and ankle - single	27.77	253.30	4
93968	- each additional (max. of 1)		94.60	add
93970	Tenodesis	27.77	258.90	4
93972	Graft	37.03	253.30	4
93974	- each additional		94.60	add
93976	Lengthening or shortening - 1	27.77	223.65	4
93978	- each additional		77.05	add
93980	Suture extensor tendon - 1	27.77	164.10	4
93982	- each additional		70.95	add
93984	Suture flexor tendon - 1	27.77	307.60	4
93986	- each additional		128.95	add
93988	Achilles tendon repair - early	27.77	227.40	4
93990	- late	27.77	387.00	4
93992	Tenotomy - open - 1 toe		87.20	4
93994	- more than 1 toe		193.00	4
93996	- closed - 1 toe (IOP)		49.20	4
93998	- more than 1 toe (IOP)		97.35	4
94000	Achilles or tibialis anterior/posterior tenotomy - open	27.77	171.70	4
94002	- closed		132.70	4
Reduction - Fractures				
94020	Ankle - no reduction, rigid immobilization		67.75	
94022	- closed reduction	27.77	144.80	4
94024	- open - 1 malleolus	37.03	237.50	4
94026	- open - multiple malleoli or ligaments	37.03	467.29	5
94027	- extensive debridement of compound fracture		217.00	add
Ankle fracture with tibial Plafond burst				
94028	- closed reduction	27.77	242.25	4
94030	- open reduction	37.03	531.48	6
94031	- extensive debridement of compound fracture		181.48	add

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
FOOT AND ANKLE (Cont'd)				
Reduction - Fractures (Cont'd)				
94032	Metatarsus - no reduction - 1 or more		49.20	
94034	- with rigid immobilization		67.75	
94036	- closed reduction - 1 or more	27.77	98.35	4
94038	- open reduction - 1	37.03	178.20	4
94040	- 2 or more	37.03	249.65	4
94041	- extensive debridement of compound fracture add		124.83	
94042	Os calcis - no reduction, rigid immobilization		97.35	
94044	- closed reduction		161.45	4
94046	- open reduction with repair of both the subtalar and calcaneocuboid joints	37.03	500.00	4
94047	- extensive debridement of compound fracture add		250.00	
Phalanx				
- no reduction, rigid immobilization				
94048	- 1		49.20	
94050	- each additional		12.05	
94052	- closed reduction - 1		72.35	4
94054	- each additional add		14.90	
94056	- open reduction	37.03	172.30	4
94057	- extensive debridement of compound fracture add		86.15	
Tarsus excluding os calcis				
94058	- no reduction - rigid immobilization		98.10	
94060	- closed reduction	27.77	165.20	4
94062	- open reduction	37.03	318.75	4
94063	- extensive debridement of compound fracture add		118.75	
Intraarticular fracture - IP joint				
94064	- closed reduction		77.95	
94066	- open reduction	27.77	144.80	4
94067	- extensive debridement of compound fracture add		72.40	
Reduction - Dislocations				
Ankle				
94080	- closed reduction	37.03	111.35	4
94082	- open reduction	37.03	252.45	4
94084	- recurrent dislocation and/or subluxation	37.03	367.45	5
Interphalangeal				
94086	- closed reduction		57.50	4
94088	- each additional add		10.25	
94090	- open reduction	37.03	151.25	4
Metatarsophalangeal				
94092	- closed reduction		57.50	4
94094	- each additional add		10.25	
94096	- open reduction	37.03	163.35	4
Tarsus				
94098	- closed reduction		147.60	4
94100	- open reduction	37.03	252.45	4

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
NOSE				
94200	EUGA of nasopharynx for malignant disease including biopsies (IOP)		41.25	4
94202	EUGA of nasopharynx, if only procedure performed (IOP)		27.54	4
94208	Insertion of prosthesis for nasal septal perforation (IOP)		18.30	
94210	Fiber-optic endoscopy of nasal cavity and/or nasopharynx (IOP)		29.87	
94212	- with fiber-optic examination of larynx		15.00	
94214	- with biopsy of larynx		10.00	
Incision (IOP)				
94220	Drainage of abscess or haematoma of septum - general anaesthetic		52.90	4
94222	Submucous turbinectomy		52.90	4
94224	Biopsy		48.45	4
Excision				
Nasal polyp (IOP)				
Excision under local anaesthetic				
94230	- single		20.00	
94232	- multiple (unilateral)		52.90	
Excision under general anaesthetic				
94234	- single		52.90	4
94236	- multiple (unilateral)		56.71	4
94238	- single choanal polyp		52.90	4
Septum				
94260	- submucous resection including septoplasty		293.65	4
94262	Partial septorhinoplasty (excluding osteotomies)		526.00	7
94264	Complete septorhinoplasty		541.65	7
94266	- with autogenous bone graft		768.45	7
94268	- bone graft autogenous	37.03	360.45	4
94270	- non-autogenous - prosthetic implant	37.03	232.00	4
94276	Septodermoplasty		306.85	4
94278	Closure of septal perforation		358.70	4
94280	Localization of cerebrospinal rhinorrhea (fluorescein injection)		86.10	4
94284	Narrowing operations or implant for atrophic rhinitis - unilateral		241.85	4
94286	Excision of intranasal lesions by lateral rhinotomy approach	37.03	470.00	7
Excision of choanal atresia				
94290	- anterior nasal approach	37.03	343.05	4
94292	- puncture and insertion of tube only		58.86	4
94296	Biopsy under local anaesthetic (IOP)		17.94	
94298	Biopsy under general anaesthetic (IOP)		48.45	4
Repair				
94310	Choanal atresia - dilation		70.25	4
Rhinoplasty for Reconstruction of Cleft Lip – Nasal Deformity				
94314	Rhinoplasty for reconstruction of cleft lip nasal deformity in adolescence or adulthood	37.03	391.02	7

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
NOSE (Cont'd)				
Removal of Foreign Body (IOP)				
	- simple		VF	
94330	- complicated, or involving general anaesthesia		48.45	4
Destruction (IOP)				
94340	Cauterization of turbinates - uni or bilateral		52.90	4
94342	Cryosurgery of turbinates - uni or bilateral		52.90	4
Treatment of Epistaxis (IOP)				
94350	Cauterization of nasal septum chemical or electrocautery		10.95	4
94352	Anterior packing		VF	4
94356	Anterior and posterior packing only		33.75	4
94360	Ligation of external carotid artery	55.54	282.85	6
94366	Endoscopic transnasal ligation of the sphenopalatine artery for posterior epistaxis – unilateral		123.70	
ACCESSORY NASAL SINUSES				
Antrum or sinus lavage (IOP)				
94370	- Proetz displacement		5.45	
94372	- Antrum or sinus lavage under local anaesthetic – unilateral		41.10	
94374	- Antrum or sinus lavage under general anaesthetic – uni or bilateral		41.10	4
Sinusotomy, sinusostomy, sinusectomy as indicated				
Maxillary				
94380	- intranasal - unilateral	37.03	119.09	4
94382	- radical, Caldwell-Luc - unilateral	37.03	235.40	4
94384	- maxillectomy	92.57	939.10	10
Frontal				
94388	- trephine and sinusectomy		134.24	4
94390	- radical		438.00	5
94392	- external fronto - ethmoidal with sphenoid if necessary	37.03	438.00	6
94394	Coronal and/or osteoplastic procedure for frontal sinusectomy, reconstruction or obliteration – unilateral or bilateral	64.80	681.60	10
Ethmoidal				
94398	- intranasal - unilateral		150.60	4
94400	- external - unilateral	37.03	343.05	4
94406	Sphenoidal - intranasal		308.46	4
Introduction				
94420	Radium application to nasopharynx (IOP)		11.99	4
Suture				
Closure of antro-oral fistula				
94430	- very simple		28.34	4
94432	- with Caldwell-Luc		203.83	5
94434	- with palatal flap		232.17	5

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
ACCESSORY NASAL SINUSES (Cont'd)				
Repair				
94436	Trans-nasal endoscopic repair of CSF rhinorrhea (includes harvesting of graft material) with or without 3D CT/MRI image guided system		822.45	15
LARYNX				
Endoscopies (IOP)				
Laryngoscopy				
Direct (under general anaesthesia)				
94440	- with or without biopsy		63.52	6
94442	- with removal of foreign body		106.45	6
94444	- with removal of lesion(s)		218.60	6
94446	- with dilation of larynx and bronchoscopy		202.35	6
Indirect				
94448	- with biopsy		22.89	6
94450	- with simple removal of bone		41.99	6
94452	Using operating microscope – add to charges for laryngoscopy		28.34	
94454	When using laser with microlaryngoscopy for benign disease, to 94444		121.65	
Introduction				
94456	Teflon augmentation larynx		163.20	6
94458	Botulinum toxin injection(s) for spasmodic dysphonia		120.00	
Excision				
Laryngectomy				
94460	- total	55.54	838.90	13
94462	- partial (laryngo-fissure)	55.54	444.85	8
94464	- with block dissection	55.54	514.48	8
94466	- hemilaryngectomy	55.54	845.85	9
94468	Arytenoidectomy	55.54	395.05	8
94470	Excision of benign growth(s)	55.54	226.35	8
Repair (including laryngoscopy)				
94480	Laryngoplasty – e.g., repair of stenosis and fractures, transections (not to be billed with 94464 or 94466)		629.85	6
94482	Arytenoidopexy		375.95	8
94484	Creation of tracheo oesophageal fistula	27.77	234.60	4
94486	Insertion of voice prosthesis (IOP)		24.60	

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
TRACHEA AND BRONCHI				
Endoscopy (IOP)				
Bronchoscopy				
94500	- with or without biopsy, suction or injection of contrast material		130.65	6
94502	- with removal of foreign body	add	40.53	6
94504	- with dilatation of stricture	add	38.80	
94506	- with selective endobronchial blocker or catheter insertion	add	46.25	
94508	- with palliative endobronchial tumour resection including laser or cryotherapy	add	61.45	
94510	- with selective brushings of all 18 segmental bronchi for occult carcinoma in situ; specimens labelled as to site	add	70.70	
94512	- with broncho alveolar lavage for obtaining specimens suitable for differential cellular analysis	add	120.50	6
94513	- with transbronchial lung biopsy under image intensification only	add	76.15	
94514	- transbronchial needle aspiration (TBNA) of mediastinal and/or hilar lymph nodes	add	104.00	
94515	- TBNA of lung mass	add	104.00	
94516	Endobronchial ultrasound (EBUS), for guided biopsy of hilar and/or mediastinal lymph nodes		203.05	
94517	- additional biopsy(s) performed by EBUS, to a maximum of 3, to 94516	add	50.75	
94520	Tracheo-bronchial toilet		28.34	
94522	Transtracheal aspiration		11.99	
94524	Triendoscopy (where 3 separate instruments are used to examine the larynx, esophagus and bronchi)		291.58	
94526	Closure of persistent tracheostoma		127.45	
94528	Change of tracheostomy tube		10.75	
Incision				
Tracheostomy (IOP)				
94530	- emergency	46.29	273.15	5
94532	- elective	46.29	273.15	5
94536	Insertion of Montgomery "T" tube or similar laryngeal or tracheal stent	37.03	205.65	8
Excision				
94540	Segmental resection cervical trachea	83.31	722.95	10
94542	- with resection of cricoid	add	229.00	
94546	Resection of mediastinal trachea with either sternotomy or thoracotomy	83.31	684.52	13
Repair				
94550	Tracheal rupture, transcervical	83.31	565.00	10

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
CHEST WALL AND MEDIASTINUM				
Incision				
94560	Excisional biopsy of rib for tumour (IOP)	27.77	137.67	4
Excision				
94570	Chest wall tumour involving ribs or cartilage and reconstruction of chest wall	83.31	500.86	13
94578	Excision of first rib and/or cervical rib to include scalenotomy when required	55.54	395.02	6
94580	Mediastinal tumour	120.34	640.06	13
94582	Anterior mediastinotomy – sole procedure	27.77	191.84	6
Endoscopies (IOP)				
94590	Mediastinoscopy	55.54	181.38	6
94592	- with bronchoscopy	55.54	240.35	6
94593	- with transbronchial biopsy under image intensification (including bronchoscopy)	55.54	271.15	6
94594	- with mediastinotomy	55.54	344.46	6
94596	- with bronchoscopy and mediastinotomy	55.54	338.55	6
Repair				
Chest Wall				
94600	- pleura – closed		IC	5
94602	- pleura – open		IC	13
94610	Pectus excavatum or carinatum repair (by reconstruction, not implant)	55.54	668.31	11
Surgical Collapse				
Thoracoplasty				
94620	- 1 stage	92.57	213.64	10
94622	- multi-stage – each	83.31	141.70	9
Pneumolysis				
94626	- intra pleural	46.29	141.70	5
94628	- extra pleural	46.29	213.64	5
Apicolysis				
94630	- extra fascial	46.29	213.64	5
94632	- extra pleura	46.29	213.64	5
94634	Phrenicotomy (IOP)	46.29	59.95	5

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
LUNGS AND PLEURA				
Introduction – Thoracentesis (IOP)				
Thoracic				
94660	- aspiration for diagnostic sample		20.26	
94662	- therapeutic drainage including sample		34.62	4
Administration of chemotherapy, including therapeutic drainage and sample				
94664	- initial		55.14	4
94666	- repeat		24.53	4
94668	Lung lavage with or without bronchoscopy for pulmonary alveolar proteinosis		184.94	13
Endoscopy (IOP)				
94680	Thoracoscopy or pleuroscopy with or without pleural biopsy, suction, etc.		201.00	5
94682	Transbronchial lung biopsy(s) including bronchoscopy		160.00	6
Incision				
94690	Biopsy of lung, needle (IOP)		68.14	4
94694	Biopsy of pleura, needle (IOP)		35.17	4
Thoracotomy				
94700	- insertion of chest tube (IOP)	27.77	80.40	4
94702	- rib resection for drainage or biopsy (IOP)	55.54	289.44	6
94704	- exploratory or removal of foreign body	120.34	378.12	13
94706	- thoracotomy with or without biopsy	120.34	378.12	13
94708	- thoracotomy for post-operative haemorrhage or empyema	120.34	378.12	13
94710	- thoracotomy with repair of ruptured diaphragm	120.34	512.85	13
94712	Insertion of permanent pleural drainage catheter		200.00	6
94714	Removal of permanent pleural drainage catheter		67.39	6
Notes:				
i) Not to be billed for simple thoracocentesis or placement of a temporary pigtail drainage catheter.				
ii) The fees for codes 94712 & 94714 include payment for local anaesthesia, thoracocentesis, aspiration, drainage and ultrasonic guidance by the physician who performs the procedure.				
94716	Decortication of lung with muscle graft and closure of pleural fistula	138.86	574.54	15
94718	Intercostal drainage with sclerosing agent (IOP)	55.54	132.97	6
Excision				
Biopsy of pleura or lung				
94730	- peripheral or parietal – including thoracotomy (IOP)	120.34	196.53	13
94732	- hilar – including thoracotomy	120.34	286.49	13
94734	Pneumonectomy – complete	120.34	926.17	14

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
LUNGS AND PLEURA (Cont'd)				
Excision (Cont'd)				
Lobectomy				
94746	- complete	120.34	926.17	13
94748	- segmental resection	120.34	926.17	13
94750	- wedge resection	120.34	482.40	13
94754	- plus decortication	138.86	IC	15
94770	Excision of broncho-pleural fistula	92.57	IC	13
94772	Pleurectomy-pleural decortication	92.57	562.80	15
94774	Sleeve resection with lobectomy	129.60	993.90	13
94780	Lung transplantation	IC	IC	IC

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
GENERAL FEES				
94800	With hypothermia and without bypass, basic fee for cardiovascular procedures			25
94802	With hypothermia - extra		202.96	
94804	Pump bypass (extra for surgeon/basic for anaesthesiologists) – (bypass includes cannulating and de-cannulating heart or major vein, major artery, supervision of pump and pump run)		461.30	28
94805	Coronary artery repair commenced on a beating heart (extra for surgeon/basic for Anaesthesiologist)		461.30	28
94806	Circulatory assist device e.g., intra-aortic balloon (includes cannulation, post-operative care and supervision)		245.94	5
94810	Decannulation of circulatory assist device (IOP)		97.12	5
94814	Repositioning of intra-aortic balloon pump (no claim to be made for repositioning within 24 hours of original insertion)		98.82	5
94818	Re-operation for failed vascular grafts – for repair or replacement of existing prosthesis (more than one month after original operation) in addition to appropriate benefit		140.25	
94820	Removal of failed vascular graft without arterial reconstruction - when sole procedure (IOP)		142.69	6
94822	Re-operation involving open heart procedures with pump (more than one month after initial operation) in addition to appropriate benefit)		140.25	
HEART AND PERICARDIUM				
94830	Cardiotomy with exploration	166.63	563.20	20
94832	- with removal of foreign body	166.63	694.62	20
94834	- with removal of tumor	166.63	553.55	20
Closure atrial septal defect				
94836	- secundum	166.63	719.63	20
94838	- endocardial cushion and valve defect	166.63	1,180.92	20
94840	- with anomalous pulmonary venous drainage	166.63	941.04	28
94842	Closure of ventricular septal defect	166.63	963.19	28
94844	Total repair trilogly	166.63	761.77	28
94846	Total repair Tetralogy of Fallot+	166.63	1,100.34	28
94848	- with previous arterial shunt	166.63	1,303.48	28
94850	Repair total anomalous pulmonary venous drainage	166.63	1,100.34	28
94852	Total correction transposition of great vessels	166.63	1,100.34	28
94854	Pulmonary valvotomy	166.63	660.20	28
94856	Pulmonary valvotomy and infundibular resection	166.63	761.77	28
94858	Tricuspid valvotomy	166.63	722.84	20
94860	Tricuspid annuloplasty	166.63	643.27	20
94862	Tricuspid valve replacement	166.63	843.25	28
94864	Mitral valvotomy	166.63	722.84	20
94866	Mitral valvotomy - re-stenosis	166.63	812.56	20
94868	Mitral annuloplasty	166.63	812.56	20
94870	Mitral replacement	166.63	1,088.66	28
94872	Aortic valvotomy	166.63	795.62	20
94874	Aortic infundibular resection (ventriculomyotomy)	166.63	914.13	28

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
HEART AND PERICARDIUM (Cont'd)				
94876	Aortic valve replacement	166.63	1,324.85	28
94878	Aortic and mitral valvotomy - closed	166.63	931.05	20
94880	Aortic, mitral and tricuspid valvotomy - closed	166.63	1,100.34	20
94900	Coronary - endarterectomy	166.63	880.27	20
94902	- done in conjunction with coronary artery repair		184.52	
	Coronary artery repair (aortic-coronary bypass graft) (includes internal mammery)			
94904	- 1	166.63	1,014.86	20
94906	- 2	166.63	1,568.41	20
94908	- 3 or more	166.63	1,780.62	20
	Implantation of internal mammery - sole procedure			
94910	- single	166.63	675.44	20
94912	- double	166.63	829.49	20
94914	Aspiration of pericardium (IOP)		151.47	
94916	Open biopsy of pericardium and drainage (transthoracic or epigastric)	166.63	295.23	13
94918	Ventricular tumour	166.63	609.41	28
94920	Ventricular aneurysm	166.63	998.78	28
94922	Aneurysm of sinus of Valsalva	166.63	880.27	28
	Pericardectomy			
94924	- 1 side open	120.34	608.90	20
94926	- both sides open or sternal split	120.34	1,199.37	20
94940	Implantation of epicardial electrode(s) - plus implantation of pack	55.54	511.63	20
	Pack replacement - see fee code 54358			
94942	Replacement or repair of epicardial pacemaker lead (IOP)	27.77	79.04	5
94943	Implantation of cardioverter-defibrillator by transvenous approach	46.29	712.54	12
94944	Removal and/or replacement of implantable cardiovertor-defibrillator (IOP)	27.77	411.77	5
94946	Implantation of coronary sinus lead for biventricular pacing	55.54	299.25	8
	Ligation or division of patent ductus			
94950	- child	120.34	507.44	20
94952	- adolescent or adult	120.34	844.80	20
	Resection coarctation			
94954	- child	120.34	660.20	20
94956	- infant under 1 year	120.34	761.77	20
94958	- adolescent or adult	120.34	931.05	20
	Congenital heart shunt procedures			
94960	- Potts	120.34	732.15	20
94962	- Blalock	120.34	655.04	20
94964	- Glenn	120.34	666.47	20
94968	Creation of ASD - by balloon septostomy	83.31	321.64	9
94970	Orthotopic cardiac transplantation	IC	IC	IC
94972	Donor cardiectomy	IC	IC	IC
94974	Cardiopulmonary transplantation	IC	IC	IC
94976	Donor heart-lung removal	IC	IC	IC
94980	Cardiac massage - open	120.34	217.73	13
94984	Thoracotomy - with or without biopsy	120.34	365.34	13
94986	- for post-operative hemorrhage	120.34	365.34	13

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
HEART AND PERICARDIUM (Cont'd)				
94988	Pulmonary artery banding	120.34	502.77	20
94990	- with pressure studies by Anaesthesiologist, extra			5
94992	Correction of cor triatriatum	166.63	702.52	20
94994	Vascular ring	166.63	719.63	20
Repair				
95000	Complete A-V canal	166.63	1,184.98	28
95002	Single ventricle	166.63	1,332.26	28
95004	Double outlet - right/left ventricle	166.63	1,184.98	28
95006	- ventricle with transposition	166.63	1,332.26	28
95008	Truncus arteriosus	166.63	1,332.26	28
95010	Interrupted aortic arch	166.63	1,184.98	28
95012	Aorto-pulmonary window	166.63	743.16	28
95014	R-V outflow tract with valve and tubular graft	166.63	829.49	28
95016	Debanding arterioplasty of pulmonary artery	166.63	744.85	28
ARTERIES				
Cannulation for infusion chemotherapy				
95050	- superficial temporal artery	27.77	73.65	4
95052	- hepatic artery	55.54	178.17	6
95054	- carotid	46.29	114.28	5
95056	Regional isolation perfusion, e.g. iliac	92.57	321.19	10
95058	Exploration of major artery	55.54	271.60	IC
Incision				
95070	Arteriotomy (IOP)		90.19	4
Note:				
95070 is <u>not</u> allowed in addition to other major cardiovascular surgery when performed at same time.				
Repair – traumatic				
95080	Suture of lacerated major artery or microscopic repair of digital artery	37.03	316.85	10
95082	Repair of lacerated major artery (including patch angioplasty)	92.57	598.40	10
95084	- by by-pass or interposition graft	92.57	467.08	10
Ligation				
95090	Ligation of artery (as sole procedure)	27.77	120.02	8
95092	- internal maxillary artery (Caldwell-Luc approach)	64.80	388.40	10
95094	- anterior ethmoid artery	55.54	285.35	6
95096	- internal iliac artery (uni or bilateral)	64.80	269.70	10

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
ARTERIES (Cont'd)				
Excision and/or Repair				
Preamble				
1. Repair of arteries implies either endarterectomy and/or by-pass graft.				
2. Fee for gas endarterectomy of coronary artery should be the same fee as for coronary endarterectomy.				
3. The fee listed for by-pass grafts include endarterectomy and/or thrombectomy of the artery being repaired.				
(a) Common femoral artery repair (e.g. 95158, 95160) includes repair to the profunda femoris artery as far as the first major branch.				
(b) If the repair extends beyond the first major branch of the profunda femoris artery, 95110 may be claimed in addition.				
(c) If the repair extends beyond the second major branch of the profunda femoris artery, 95188 instead of 95110 may be claimed in addition.				
For procedures involving the application of a complete aortic cross clamp, the anaesthetic basic fee will depend on:				
(a) the level of application of the cross clamp,				
(b) the surgical exposure and extent of the aortic repair.				
	<u>Surgical Exposure</u>			
95100	- Abdominal			20
95102				17
95106	- Thoracic			25
95108	- Thoraco-abdominal			30
95110	Anterioplasty with or without patch graft including microvascular anastomosis, arterial and/or venous, (other than listed below)	92.57	405.96	10
95112	Carotid - endarterectomy	92.57	666.65	10
95114	- carotid body tumour	92.57	715.76	10
95116	- aneurysm - reconstruction or excision with graft	92.57	763.04	10
Aortic arch reconstruction				
95118	Innominate	92.57	799.46	10
95120	Subclavian	92.57	785.77	10
95122	Vertebral	92.57	720.89	10
95124	- with thoracotomy	27.77	140.54	7
95126	- ruptured		221.62	3
Thoracic aorta aneurysm - repair or excision with graft				
95128	- ascending	92.57	1,318.53	20
95130	- arch	92.57	1,637.14	20
95132	- descending with or without temporary shunt	92.57	1,047.18	20
95134	- ruptured		221.62	3
95136	Thoraco - abdominal aneurysm	166.63	2,213.78	30

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
ARTERIES (Cont'd)				
Excision and/or Repair (Cont'd)				
95138	Abdominal aorta - aneurysm	92.57	1,084.28	17
95140	- plus unilateral common femoral repair	92.57	1,181.43	17
95142	- plus bilateral common femoral repair	92.57	1,275.09	17
95144	- plus implantation of inferior mesenteric artery		160.68	
95146	- ruptured		287.77	3
95148	Endovascular aneurysm repair using stent grafting	92.57	1,396.90	17
	Mesenteric or celiac artery repair			
95150	- aneurysm	92.57	341.33	10
95152	- excision of celiac ganglion or removal of band only	92.57	341.33	10
95154	- endarterectomy or graft	92.57	785.77	10
	Aorto-iliac repair			
95156	- including common iliac repair (uni or bilateral)	92.57	916.56	17
95158	- plus unilateral common femoral repair	92.57	1,075.81	17
95160	- plus bilateral common femoral repair	92.57	1,190.83	17
95162	- plus implantation of inferior mesenteric artery		160.68	
95164	- embolectomy or thrombectomy of bifurcation (aorta or graft)	92.57	417.94	10
95166	Total removal of infected aortic graft (stem and limbs) (arterial reconstruction extra)	92.57	763.95	17
95168	Closure of duodenum		105.61	
95170	Partial removal of infected aortic graft (one limb only) (arterial reconstruction extra)	92.57	311.71	10
95172	Renal artery - aneurysm - reconstruction or excision with graft	92.57	720.89	10
95174	Renal artery repair	92.57	720.89	10
95176	Splenic artery aneurysm - reconstruction or excision with graft	92.57	341.33	10
95178	Iliac repair to include internal iliac aneurysm	92.57	729.66	10
95180	Ilio-femoral by-pass graft	92.57	729.66	10
	Per-obturator ilio-femoral graft			
95182	- with saphenous vein	92.57	814.65	10
95184	- with prosthetic graft	92.57	729.51	10
95186	Common femoral/profunda femoris repair (profundoplasty) when sole procedure performed	92.57	506.56	10
95188	Extended profundoplasty	92.57	706.66	10
95190	Axillo-femoral, femoro-femoral or axillo-axillary graft	92.57	656.55	10
95192	Aorto-femoral unilateral graft (for bilateral see 95160)	92.57	785.77	17
95194	Femoral aneurysm - reconstruction or excision with graft	92.57	543.70	10
95196	Repair of false aneurysm at groin anastomosis	92.57	809.39	10
95198	Femoral-popliteal endarterectomy	92.57	687.99	10
	Femoro-popliteal (with or without endarterectomy)	92.57		
95200	- with saphenous vein	92.57	776.59	10
95204	- with prosthetic graft	92.57	607.67	10
	Femoro-anterior/posterior tibial/peroneal by-pass graft (with or without endarterectomy)			
95206	- with saphenous vein	92.57	801.14	10
95210	- with prosthetic graft	92.57	809.02	10
95212	Popliteal aneurysm	64.80	729.66	10
95214	Peripheral arteries other than listed - aneurysm	64.80	371.84	10
95216	Embolectomy - artery or graft (as sole procedure)	64.80	490.00	10
95218	Thrombectomy - artery or graft (as sole procedure)	64.80	490.00	10

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
ARTERIES (Cont'd)				
Excision and/or Repair (Cont'd)				
95220	Embolectomy and/or thrombectomy when done in conjunction with other vascular procedures		112.45	
95222	Gastric devascularisation - when sole procedure	92.57	422.52	10
	In-situ saphenous vein arterial by-pass			
95224	- popliteal	92.57	1,164.42	17
95226	- tibial	92.57	1,350.09	17
VEINS				
Excision				
Resection of AV aneurysm or fistula with or without major graft				
95240	- major aneurysm	92.57	974.39	17
95242	- minor aneurysm	92.57	497.25	10
Ligation				
95250	Saphenous (IOP)		48.18	4
95252	Femoral (IOP)	27.77	68.42	4
95254	Popliteal (IOP)	27.77	68.42	4
95256	Internal jugular (IOP)	46.29	134.61	5
95258	Internal iliac	55.54	357.72	10
95260	IVC - transabdominal	55.54	411.70	10
95262	- transvenous (umbrella)	55.54	330.89	10
95264	High ligation and stripping of long saphenous vein with groin dissection	37.03	208.61	4
95266	Stripping of short saphenous vein with popliteal dissection	37.03	97.37	4
95268	Multiple ligation and avulsion	37.03	200.00	4
95270	Recurrent varicose veins - multiple ligation and/or stripping	46.29	320.38	5
95272	Extra fascial and sub-fascial incompetent perforators by full fascial technique	46.29	348.65	6
95274	- plus stripping		115.94	
Repair				
95290	Lacerated major vein, e.g., femoral, popliteal, vena cava, axillary, subclavian, brachial or microscopic repair of digital vein	37.03	273.14	4
95292	- including patch	92.57	450.45	10
95294	- by vein graft	92.57	793.55	10
95296	SVC by-pass graft	64.80	630.91	17
95298	Pulmonary embolectomy	166.63	720.18	20
95300	Ilio-femoral thrombectomy with or without femoral vein ligation	92.57	404.44	10
95304	Thrombectomy, other than above	64.80	302.80	10
95306	Distal spleno-renal shunt	92.57	1,047.37	10

VEINS (Cont'd)

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
Anastomosis				
95320	Porto-caval	92.57	763.66	10
95326	Meso-caval		816.92	10
95328	Creation of AV fistula	37.03	440.00	6
95330	Obliteration of AV fistula		82.55	4
95332	Ligation or removal of by-pass graft		82.55	4

SURGICAL PROCEDURES

OPERATIONS ON THE HAEMIC AND LYMPHATIC SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SPLEEN AND MARROW				
Incision (IOP)				
95350	Splenic puncture and aspiration		43.60	4
	Bone marrow			
95352	- aspiration		40.01	4
95354	- interpretation of marrow smear, including assessment of peripheral smear and iron stain		25.66	
95356	- aspiration and interpretation		65.67	
95358	Core biopsy (with biopsy needle)		63.35	4
	Bone marrow transplantation - team fee			
95360	- aspiration from donor	IC	IC	IC
95362	- infusion into recipient	IC	IC	IC
Excision				
95370	Splenectomy	64.80	502.50	7
95372	Bone button (IOP)		35.97	4
LYMPH CHANNELS				
Excision				
95380	Cystic hygroma	55.54	231.68	6
LYMPH NODES				
Incision				
95400	Drainage of sub-fascial abscess (IOP)		77.23	4
Excision				
95413	Neck - limited dissection, must include 2 levels (unilateral) or central compartment	74.06	568.70	8
95415	Neck - comprehensive dissection, must include 3 or more levels, unilateral	74.06	1,120.80	8
95418	Ilioinguinal, radical resection	55.54	308.91	8
95420	Axillary or inguinal nodes, radical resection	37.03	371.84	4
	Biopsy (IOP)			
95426	- cervical, axillary, inguinal	37.03	64.31	4
95428	- scalene	37.03	124.62	4
95430	- sentinel node biopsy (per draining basin)	55.54	330.45	6
95438	Staging pelvic lymphadenectomy	64.80	172.22	7

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
MOUTH				
Incision				
95450	Drainage of Ludwig's Angina, complete care		70.85	5
95452	Biopsy (IOP)		33.75	4
Excision				
95460	Simple excision of lesion (IOP)	37.03	67.55	4
95462	Excision of ranula	37.03	157.80	4
95464	Composite resection of lesion of oral cavity and/or oropharynx with partial resection of mandible	92.57	1,030.70	12
95466	Extended composite resection of lesion of oral cavity and oropharynx with partial resection of mandible and resection of maxilla	92.57	1,059.45	12
95468	Excision of intra-oral tumour (greater than 2.0 cm. average diameter)	37.03	325.80	6
95470	Oro-pharyngeal carcinoma - excision floor of mouth, mandible and glands of neck	74.06	490.50	12
	Cryosurgery or treatment of premalignant or malignant lesion(s) of oral cavity or sinuses			
95474	- minor		52.32	4
95478	- intermediate		132.98	4
95482	- major - initial		185.30	6
95484	- repeat within 30 days		92.65	6
LIPS				
Incision				
95490	Biopsy (IOP)		35.40	4
Excision				
95500	Wedge resection of lip vermillion	27.77	98.45	4
95502	Resection of lip with plastic repair	37.03	275.00	4
95504	Excision of lesion (IOP)	37.03	90.47	4
95506	Lip shave (Leukoplakia)	37.03	225.00	4
Reconstruction				
95510	Cleft lip - unilateral	74.06	363.30	8
95511	- with nasal cartilage realignment, to 95510		304.30	add
95512	Reconstruction with lip switch flap	74.06	444.40	8
95514	Complex reconstruction or revision of previous repair and excision	IC	IC	IC

Note:

Cleft lip reconstruction (95510, 95511, 95512, 95514) is not eligible for payment with 94314).

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
TONGUE				
Incision (IOP)				
95520	Biopsy		33.75	4
	Tongue tie			
95524	- release under local anaesthetic		48.45	
95526	- release under general anaesthetic		48.45	4
Excision				
	Glossectomy			
95530	- partial	74.06	187.95	8
95532	- complete	74.06	268.30	8
95534	Wedge resection of lesion (IOP)		58.35	4
Repair				
95540	Glossoplasty	37.03	187.95	4
Suture				
95550	Extensive laceration	37.03	IC	4
TEETH AND GUMS				
Incision				
95560	Drainage of alveolar abscess, general anaesthetic (IOP)		48.45	4
Excision				
	Extraction of tooth (complete care)			
95564	- single		30.00	4
95566	- each additional tooth add		15.00	
PALATE AND UVULA				
Incision				
95570	Palate abscess (IOP)		21.80	4
95572	Fenestration of palate for radiotherapy			4
95574	Biopsy of palate (IOP)		33.75	4
Excision				
95580	Uvulectomy or biopsy of local lesion (IOP)		33.75	4
Repair				
95590	Cleft palate	74.06	369.25	8
95592	Removal of sutures		35.40	4
95594	Bone graft to palate	55.54	335.65	8
Closure of fistula				
95600	- anterior alveolar	37.03	197.45	4
95602	- palate	55.54	281.95	6

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SALIVARY GLANDS AND DUCTS				
Incision				
Sialolithotomy				
95610	- simple	37.03	37.06	4
95612	- complicated	37.03	98.60	4
95614	Biopsy (IOP)	37.03	42.70	4
Excision				
95620	Submaxillary gland	37.03	391.05	4
Parotid gland				
95622	- total - with preservation of facial nerve	37.03	885.75	8
95624	- without preservation of facial nerve	37.03	593.00	8
95626	- subtotal - with preservation of facial nerve	37.03	752.10	7
95630	- without preservation of facial nerve	37.03	395.45	6
95634	Excision small tumor	37.03	51.23	4
Introduction				
95638	Botulinum toxin injection(s) for sialorrhea (unilateral or bilateral)		50.00	
Repair				
95640	Plastic repair of duct	37.03	202.25	4
95642	Dilation of duct (IOP)		43.15	4
Probing				
95650	Duct (IOP)		7.09	
PHARYNX, ADENOIDS AND TONSILS				
Incision				
95660	Drainage of retropharyngeal, intra-oral or peritonsillar abscess (IOP)		48.45	4
95662	Drainage of lateral pharyngeal abscess	37.03	145.95	4
95668	Biopsy of pharynx (IOP)		33.75	4
Excision				
Branchial				
95670	- cyst	37.03	292.00	4
95672	- sinus	37.03	292.00	4
95674	- fistula	37.03	292.00	4
95676	Thyroglossal duct, cyst, sinus or fistula	37.03	292.00	4
95678	- recurrent procedure	37.03	390.55	4
Tonsillectomy, includes adenoidectomy				
95680	- child under 16		178.35	4
95682	- adolescent or adult		178.35	4
95684	Adenoidectomy only - child or adult		101.25	4
95686	Secondary suture following T and A		121.05	4

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
PHARYNX, ADENOIDS AND TONSILS (Cont'd)				
Excision (Cont'd)				
95688	Excision of parapharyngeal space lesions with mobilization of parotid gland	37.03	583.05	8
95690	Pharyngectomy - trans-hyoid or lateral	74.06	752.75	11
95692	Pharyngo-laryngectomy	74.06	1,155.45	14
Repair				
95696	Pharyngoplasty	74.06	360.45	8
OESOPHAGUS				
For procedures on the oesophagus the following basic fees for Anaesthesiologists and Assistants will apply <u>except</u> for endoscopies.				
95700	- cervical approach	55.54		7
95702	- thoracic approach	120.34		13
95704	- abdominal approach	64.80		8
Endoscopies with or without biopsies (IOP)				
95710	Oesophagoscopy		72.04	4
95712	- with removal of foreign body add		43.87	
95713	- with brushing of oesophagus, stomach and/or duodenum add		46.30	
95714	- with injection of varices, initial add		38.60	
95716	- with injection of varices, subsequent add		38.60	
95718	- with dilation		69.70	
95720	- with bronchoscopy		59.59	2
95722	- with gastroscopy and gastric photography, same intubation add		41.58	
95724	- with gastroscopy and gastric photography, separate intubation ... add		52.32	
95726	- with gastroscopy with or without duodenoscopy		50.93	2
95728	- with gastroduodenoscopy with cannulation of pancreatic and/or common bile duct add		242.76	2
95730	- management of uncomplicated upper gastrointestinal bleeding, by any technique		61.30	2
95732	- management of complicated upper gastrointestinal bleeding by any technique in haemodynamically unstable patients with active bleeding during endoscopy		84.70	2
95734	- with snare polypectomy first polyp (>1 cm)		59.76	
95736	- each additional polyp, by snare polypectomy (>1 cm) (to a maximum of 2)		29.88	
Incision				
Oesophagostomy				
95750	- cervical - other than neonatal		154.45	
95752	- neonatal		213.64	
95754	- thoracic		213.64	

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
OESOPHAGUS (Cont'd)				
Excision				
95770	Intrathoracic diverticulum		507.00	
95772	Crico pharyngeal diverticulum		390.05	
95776	Partial oesophageal resection and reconstruction (including intestinal transposition)		1,081.55	17
95778	Resection of oesophagus		607.14	
95780	Total resection of oesophagus		1,465.35	17
95781	- with reconstruction	add	678.85	
95782	Oesophago-gastrectomy		1,185.92	
Repair				
95794	Oesophagoplasty		330.89	
95796	Heller procedure		617.25	
95797	- with oesophageal hiatus hernia repair to 95796	add	217.35	
Oesophageal hiatus hernia				
95798	abdominal or transthoracic approach with fundoplication		750.00	
95802	- recurrent		967.10	
95804	- with oesophagopasty	add	110.38	
95806	Ruptured oesophagus		526.46	
95808	Oesophago-gastrostomy		608.30	
95810	Oesophageal bypass, cervical		912.60	
95812	Oesophageal stricture (Thal) – may include oesophageal hiatus hernia repair with or without gastroplasty, cervical		676.05	
Suture				
95820	Closure of oesophago-tracheal fistula		923.05	
Dilation of oesophagus without oesophagoscopy (IOP)				
95830	- (active) with or without guiding string		35.97	
95832	- (passive) using mercury filled tubes		26.16	
95836	- pneumatic dilatator		110.85	
95842	- retrograde dilatation		14.17	
STOMACH				
Incision				
Gastrostomy				
95870	- with removal of tumour or foreign body	64.80	406.85	7
95872	- with suture of bleeding peptic ulcer	64.80	653.87	9
95874	Pyloromyotomy (Ramstedt's)	92.57	452.14	10
95876	Gastrostomy	64.80	345.85	7
95878	Full thickness revision gastrostomy	55.54	228.84	6

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
STOMACH (Cont'd)				
Excision				
Biopsy (IOP)				
95890	- by gastroscopy		84.62	4
95892	- by gastrotomy		47.09	
	if sole procedure claim <u>also</u> 96636			
95894	- by intubation		22.01	
Gastrectomy				
95900	- wedge resection for ulcer	64.80	520.00	7
95906	- partial or subtotal, with or without vagotomy	64.80	840.00	8
95916	- plus repair of hiatus hernia	64.80	946.55	8
95918	- after previous gastroenterostomy	64.80	946.55	8
95920	- after previous partial gastrectomy	64.80	657.55	8
95922	- total gastrectomy	64.80	1,235.00	9
95932	Excision of gastroduodenal lesion, recurrent ulcer	64.80	651.33	8
95934	Excision of gastrojejunal lesion, recurrent ulcer	64.80	651.33	8
95936	Vagotomy	64.80	387.55	7
Bariatric Surgery				
95938	Gastric bypass for morbid obesity	64.80	1,000.00	10
95940	Sleeve Gastrectomy	64.80	1,000.00	10
95942	Adjustable gastric banding	64.80	1,000.00	10
95944	- with oesophageal hiatus hernia repair to 95938 or 95940 or 95942 add		217.35	
Repair				
95950	Pyloroplasty	64.80	406.85	7
95952	Pyloroplasty and vagotomy	64.80	528.85	7
95956	Gastroduodenostomy or gastrojejunostomy	64.80	406.85	7
95962	Either of above plus vagotomy	64.80	554.15	7
95964	Pyloroplasty and vagotomy plus repair of oesophageal hiatus hernia	64.80	483.64	7
95966	Pyloroplasty or gastroenterostomy with vagotomy and cholecystectomy	64.80	492.07	8
Suture				
95980	Closure of gastrostomy or other external fistula of stomach	46.29	345.85	6
95982	Gastrorrhapy (for perforated ulcer or wound)	64.80	503.15	7
95984	Closure of gastrocolic fistula	64.80	574.40	7

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
INTESTINES (EXCEPT RECTUM)				
Endoscopy, includes dilation for access (IOP)				
96000	Duodenoscopy, with or without biopsy		109.00	4
96006	Small bowel push enteroscopy		185.14	4
Endoscopic retrograde cholangiopancreatography (ERCP)				
96010	- with cannulation of pancreatic and/or common bile duct		213.15	4
96020	- with intraductal cytology brushing or intraductal biopsy..... add		49.75	
Colonoscopy using flexible scope				
96030	- of sigmoid to descending colon		60.61	4
96032	- to splenic flexure		60.13	
96034	- to hepatic flexure		43.12	
96036	- to caecum		34.50	
96038	- into terminal ileum		31.65	
96040	- if biopsy(s) and/or coagulation of angio-dysplastic lesion(s)		27.05	
96041	- management of uncomplicated lower gastrointestinal bleeding, by any technique		46.30	
96042	- multiple screening biopsies (> 34 sites) for malignant changes in ulcerative colitis, to 96030 only		54.25	
96044	- hydrostatic - pneumatic dilatation of colon stricture(s) through colonoscope		107.50	
96046	Fulguration or snaring of polyp through colonoscope		49.80	
96048	- each additional polyp, (max. of 4)		24.25	
96050	Excision of polyp through colonoscope		150.15	4
96052	- each additional polyp, (max of 2)		77.50	
96054	Total excision of very large sessile polyp (>3cm) through colonoscope, and may include fulguration, each		227.65	
Incision				
Enterotomy				
96060	Ileostomy	55.54	406.85	7
Small intestine				
96062	- including excision of polyps or biopsy	55.54	406.85	7
96064	Insertion of feeding enterostomy (as sole procedure)	55.54	376.77	7
96066	- when done with another intraabdominal procedure		82.35	
Large intestine				
96068	- including excision of polyps	55.54	406.85	7
96074	Colostomy	55.54	478.45	6
96076	Caecostomy	55.54	387.40	6

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
INTESTINES (EXCEPT RECTUM) (Cont'd)				
Incision (Cont'd)				
96078	Revision of stenosis or obstruction more than 4 weeks after original operation	55.54	82.73	6
96080	Entero-enterostomy	55.54	406.85	7
Excision				
96090	Biopsy by intubation (IOP)		84.68	4
96092	Local excision of lesion of intestine	55.54	528.85	7
96094	Resection of exteriorized intestine	55.54	165.44	6
Enterectomy with anastomosis				
Small intestine				
96096	- duodenum	55.54	746.10	7
96098	- other	55.54	687.55	7
Small and large intestine				
96100	- terminal ileum, caecum and ascending colon	55.54	799.55	7
96102	Large intestine - any portion	55.54	799.55	7
96106	Ileostomy, subtotal colectomy	55.54	1,057.70	7
96108	Total colectomy with ileorectal anastomosis	74.06	1,242.90	9
96112	Ileostomy plus total colectomy plus abdomino-perineal resection	74.06	1,566.58	10
96114	- 2 stage procedure - (1 st stage)	74.06	878.86	10
96116	- (2 nd stage)			6
96122	- repair of entero-cutaneous fistula in conjunction with bowel resection		347.63	
Intestinal Obstruction (Mechanical)				
96130	Without resection - adult	55.54	538.26	6
96132	- child	55.54	476.15	6
96134	With entero-enterostomy	55.54	538.26	7
96136	With resection	55.54	645.91	7
96140	Intestinal atresia (newborn)	55.54	682.90	7
96142	Meconium ileus	55.54	682.90	7
Repair				
Revision of ileostomy or colostomy				
96152	- skin level	46.29	131.75	5
96154	- full thickness	55.54	350.65	6
96162	Caecopexy or sigmoidopexy (as sole procedure)	55.54	314.80	6
96164	Formation of an ileal pouch and primary anastomosis following total colectomy		1,549.49	7
Suture				
96170	Suture of intestine	55.54	376.57	6
Closure of colostomy or enterostomy				
96174	- with resection	55.54	406.85	7
96176	- without resection	46.29	406.85	7
96178	Plication of small intestine for adhesions	55.54	433.55	7

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
INTESTINES (EXCEPT RECTUM) (Cont'd)				
Manipulation (IOP)				
96190	Reduction of prolapse		25.25	4
96192	Dilation of enterostomy, colostomy, etc.		25.25	4
96196	Intubation of small intestine (with or without fluoroscopy)		79.80	4
MECKEL'S DIVERTICULUM AND THE MESENTERY				
Excision				
96200	Meckel's diverticulum	46.29	376.78	6
96204	Local excision of lesion	46.29	305.05	6
96206	Resection of mesentery	46.29	325.40	6
96208	Biopsy through laparotomy	46.29	165.44	6
APPENDIX				
Incision				
96220	Drainage of abscess, complete care	46.29	239.20	6
Excision				
96230	Appendectomy	46.29	367.12	6
96232	- with gross perforation and peritonitis	46.29	451.50	6
RECTUM				
Endoscopy, includes dilation for access (IOP)				
96240	Sigmoidoscopy - rigid scope		36.80	4
96242	- with biops(ies)		44.55	4
96244	- with anoscopy (separate instrumentation)		29.70	4
Incision				
Proctotomy				
96250	- with exploration	37.03	77.06	4
96252	- with decompression (imperforate anus)	37.03	77.06	4
96254	- with drainage (perirectal abscess)	37.03	71.94	4
Excision				
Proctectomy				
96260	- Anterior resection or proctosigmoidectomy (anastomosis below peritoneal reflection)	55.54	1,100.00	8
96262	Abdomino-perineal resection or pull through	74.06	1,300.00	10
96268	Hartmann procedure	55.54	890.00	9
96270	Reversal of Hartmann procedure	74.06	1,030.00	9
96272	Proctosigmoidectomy for prolapse	55.54	605.61	9
96274	Biopsy of rectosigmoid for Hirschsprung's disease (IOP)	27.77	82.35	4

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
RECTUM (Cont'd)				
Excision (Cont'd)				
96278	Presacral or transsacral proctotomy and excision of lesion	37.03	350.65	6
	Polyps or tumours of rectum or sigmoid (max. 2 polyps any size or technique) (IOP)			
96280	- electrocoagulation - base under 2 cm.		24.25	4
96282	- excision - base under 2 cm.	27.77	82.35	4
96284	- electrocoagulation or excision - base over 2 cm.	27.77	149.03	4
96286	Transanal Endoscopic Microsurgery	55.54	793.00	7
	Notes:			
	1. Restricted to fellowship trained colorectal surgeons			
	2. Paid only if a sealed and insufflating operating proctoscope is employed with visualization via an endoscopic camera.			
	3. Sigmoidoscopy/colonoscopy not billable with this procedure			
	4. Limited for use in the following conditions (one or more):			
	a. Lesions not amenable to colonscopic resection			
	b. Select low grade malignancies			
	c. Complex anorectal fistulas			
Repair				
96290	Anastomosis of rectum	37.03	488.20	6
96292	Proctostomy	37.03	211.26	4
Rectal prolapse				
96300	Excision of mucous membranes	27.77	239.20	4
96302	Perineal repair, major	37.03	387.55	4
96304	Abdominal approach	55.54	554.10	8
96306	Insertion of Thiersh wire	27.77	190.85	4
Suture				
Suture of rectum, trauma				
96310	- external approach	37.03	239.20	4
96312	- intraperitoneal approach	55.54	384.00	6
Closure of fistula				
96314	- recto vaginal (any repair)	37.03	430.61	6
96316	- recto vesical	37.03	446.90	6
Manipulation (IOP)				
96320	Dilation and/or disimpaction under general anaesthesia (sole procedure)		58.15	4
96322	Fecal disimpaction - no anaesthetic		36.80	
96324	Removal of foreign body	IC	IC	IC

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
OPERATIONS ON THE ANUS				
Endoscopy, includes dilation for access				
96330	Proctoscopy (IOP)		7.09	
Incision				
96340	Biopsy (IOP)		34.90	4
96342	Thrombosed haemorrhoid (IOP)		25.25	4
96344	Sphincterotomy	27.77	170.84	4
96346	- with repair of fissure	27.77	309.63	4
Excision				
96350	Local excision of lesion, e.g., fissure	27.77	78.41	4
96352	Haemorrhoidectomy, with or without sigmoidoscopy or repair of fissure	27.77	309.63	4
96354	Complete haemorrhoidectomy using cryotherapy and/or Barron ligation(s) including rectal dilation (IOP)		99.60	
96356	Barron non-operative haemorrhoidectomy (IOP)		34.60	
96360	Local excision for malignancy	27.77	153.05	4
96364	Anal polyp, haemorrhoidal tags	27.77	47.15	4
96366	Fistula-in-ano	27.77	309.63	4
96368	Perineal pull through for imperforate anus	27.77	124.72	4
Introduction				
96380	Haemorrhoid injections, max. of 4 in any one year		27.05	
96382	Injections (including botulinum toxin) for pruritus ani or fissure		35.90	6
Repair				
96396	Excision of scar for stenosis	27.77	142.40	4
96398	Anoplasty, for stenosis	37.03	275.05	4
96400	Repair of anal sphincter	37.03	275.05	4
96402	Repair of anal sphincter and ano-rectal ring	37.03	356.50	
Destruction (IOP)				
96410	Curettage of fissure or fistula		33.09	4
96412	Cauterization of fissure		34.90	4
96416	Fulguration of condylomata		42.64	4
Manipulation				
96420	Dilation of anal sphincter (IOP)		12.05	4

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
LIVER				
Incision				
96430	Biopsy - incisional (IOP)		102.10	
96432	- needle (IOP)		72.80	4
96434	Hepatotomy	64.80	249.44	7
Excision				
Hepatectomy				
96436	- local excision of lesion	64.80	429.54	7
96438	- lobectomy (includes cholecystectomy)	111.08	1,022.69	8
Formal Anatomical Resection				
96442	- one or two liver segments		1,184.60	12
96444	- three or four liver segments		1,652.15	12
96448	- five or more liver segments		1,784.60	12
Note:				
Cholecystectomy is not eligible for payment in conjunction with liver lobectomy involving liver segments #4 and/or #5, or formal anatomic resection involving liver segments #4 and/or #5.				
96450	Laparotomy, cholangiogram and biopsy (neonatal jaundice)	55.54	228.52	6
Liver transplant				
96452	- donor	IC	IC	16
96454	- recipient	IC	IC	IC
Repair				
96460	Marsupialization of cyst or abscess	64.80	249.44	7
Suture				
96470	Rupture or wound	74.06	249.44	8

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
BILIARY TRACT				
Endoscopy, to include examination of stomach and duodenum (IOP)				
96480	Manipulation and/or removal of common bile duct stones with or without sphincterotomy		482.40	5
96482	Subsequent procedure (within 3 months of previous endoscopic procedure)		76.30	5
Incision				
96504	Biliary duct calculus manipulation and/or removal via T-tube tract – when sole procedure performed (IOP)		116.20	7
96508	Cholecystostomy	64.80	408.05	7
96510	Choledochotomy	64.80	333.43	7
96514	Transduodenal sphincterotomy and choledochotomy (previous cholecystectomy)	64.80	844.65	9
96516	Choledochoduodenostomy	64.80	721.70	9
96518	Cholecystogastrostomy	64.80	447.45	7
96520	Cholecystoenterostomy	64.80	447.45	7
96524	Hepatic choledochoenterostomy	64.80	915.30	9
Excision				
96530	Cholecystectomy with or without cholangiogram	64.80	482.17	7
96532	Cholecystectomy and choledochotomy	64.80	592.08	8
96534	Cholecystectomy, choledochotomy and transduodenal sphincterotomy	64.80	711.94	9
96536	Cholecystectomy and hiatus herniorraphy	64.80	657.46	7
96542	Choledochectomy	64.80	414.88	8
Repair				
96550	Common duct stricture	64.80	498.89	10

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
PANCREAS				
Incision				
96560	Biopsy - needle (IOP)		102.10	
96562	- incisional (IOP)		122.05	7
96564	Pancreatotomy	64.80	406.85	7
Excision				
Pancreatectomy				
96570	- complete	64.80	1,270.20	11
96572	- partial resection of head	64.80	1,005.00	11
96574	- "Whipple Type" operation	64.80	1,785.45	15
96576	- local excision of lesion	64.80	508.55	8
96578	- islet cell tumor	64.80	411.00	8
96582	Resection of entire body and tail of pancreas, spleen	83.31	986.05	11
96584	Excision pancreatic cyst	64.80	337.95	7
96586	Biopsy of other retroperitoneal lesion (IOP)		76.36	7
Repair				
96590	Pancreatic - cystogastrostomy	64.80	589.95	8
96594	- cystojejunostomy	64.80	589.95	8
96596	Marsupialization of cyst	64.80	249.44	8
96598	Anastomosis of body and tail of pancreas to intestine (Puestow operation)	83.31	813.60	10
LINEAR OR RADIAL ECHO-ENDOSCOPE (ENDOSCOPIC ULTRASOUND)				
Upper gastrointestinal tract linear or radial echo-endoscopy				
96601	- excluding biliary or pancreatic examination (scope also used for therapeutic purposes)		197.73	4
96602	- including biliary and/or pancreatic examination (scope also used for therapeutic purposes)		246.50	4
96603	Lower gastrointestinal tract linear or radial echo-endoscopy (scope also used for therapeutic purposes)		130.00	4
Add-ons for both upper and lower gastrointestinal tract linear or radial echo- endoscopy				
96604	- biopsy or fine needle aspiration, to a maximum of 3, per lesion add		50.75	
96605	- dilation of stricture..... add		30.65	
96606	- injection of one or more of any of the following: metastases, nodes, masses or celiac plexus..... add		145.05	
96607	- drainage of pseudocyst (including stent insertion if performed) add		203.05	

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
ABDOMEN, PERITONEUM AND OMENTUM				
General				
96610	Surgeon called to assist at an intra-procedural emergency, e.g., acute bleed during an abdominal procedure already in progress (claim IC)		178.22	
Paracentesis (IOP)				
96620	Aspiration for diagnostic sample		31.30	
96622	Aspiration with therapeutic drainage with or without diagnostic sample		57.65	4
96626	Paracentesis with lavage for diagnosis		50.71	4
Incision				
96630	Biopsy of omentum (single or multiple) (IOP)		48.00	
96632	Needle biopsy of peritoneum (IOP)		22.18	
96634	Open lavage of peritoneal cavity for diagnosis without manual exploration of peritoneal cavity (IOP)		48.36	4
96636	Laparotomy (biopsy extra)	55.54	319.94	6
96642	Laparotomy for acute trauma	55.54	397.15	6
96644	- with repair of intestine, single		142.40	3
96646	- multiple or with resection		284.75	3
96648	- with splenectomy	18.51	284.75	3
96650	- with repair of lacerated liver	18.51	187.90	3
96652	- with repair of diaphragm	18.51	122.05	2
Peritoneal abscess				
96660	- subphrenic	64.80	370.95	7
96662	- abdominal	55.54	264.45	6
96664	Pelvic abscess, incision drainage - rectal or vaginal approach (IOP)		122.05	4
96670	Removal of infected sutures from abdominal wall - general anaesthetic (IOP)		94.85	4
96672	Umbilical vein intraabdominal dissection and catheterization	55.54	232.50	6
Insertion of peritoneo - jugular shunt for ascites				
96676	- primary	64.80	281.85	7
96678	- revision within 30 days	64.80	208.15	7
Excision				
96690	Desmoid tumour, depending on extent	37.03	IC	6
96694	Umbilectomy - plastic	37.03	78.41	4
96700	Panniculectomy	37.03	500.00	6
96701	- with repair of umbilical hernia		122.05	
96702	Mesenteric cyst	55.54	335.15	6
Endoscopy				
Peritoneoscopy or laparoscopy (IOP)				
96710	- without biopsy		146.12	6
96712	- with biopsy and/or lysis of adhesions and/or removal of foreign body and/or cautery of endometrial implants		161.16	6
96714	Laser treatment of extensive pelvic disease (includes laparoscopy)		211.55	6

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
ABDOMEN, PERITONEUM AND OMENTUM (Cont'd)				
Repair				
96720	Omentopexy, as sole operative procedure	55.54	305.05	6
	Herniotomy			
96722	- Inguinal or femoral - single	37.03	331.80	4
96728	- with hydrocele	37.03	417.29	4
96730	- Unilateral with exploration of other side - infants and children	37.03	329.30	4
	- Strangulated or incarcerated			
96732	- without resection of bowel	55.54	467.09	4
96734	- with resection of bowel	55.54	660.50	7
96736	- Inguinal and femoral - same side	37.03	414.76	4
	- Umbilical			
96738	- adolescent or adult	37.03	313.30	4
96740	- child (operative)	37.03	165.44	4
96742	- umbilical hernia repair when done in conjunction with other abdominal surgery, to other surgery		96.85	
	Omphalocele and gastrochisis			
96748	- 1 stage repair	64.80	375.80	7
	- multiple staged repair			
96750	- gross method of silon mesh	64.80	375.80	7
96752	- second stage repair (completion of abdominal wall closure)	64.80	382.35	7
	Diaphragmatic, other than oesophageal hernia - 1 stage procedure			
96754	- trans-abdominal	83.31	576.90	9
96756	- trans-thoracic	120.34	576.90	13
96760	Ventral	55.54	403.03	6
96762	Massive incisional hernia	55.54	500.00	6
96770	Epigastric	37.03	284.97	4
96772	- recurrent - all types		130.00	
	Note:			
	Fee code 96772 can only be billed as an add-on to fee codes 96722 – 40, and 96754 – 96770.			
Suture				
96780	Secondary closure for evisceration (sole operative procedure in abdomen)	55.54	350.00	6

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
KIDNEYS AND PERINEPHRUM				
1.	<u>No</u> additional claim should be made for nephroscopy when done at the time of pyelolithotomy or nephrolithotomy.			
2.	In a routine surgical approach to the kidney and related procedures, <u>no</u> additional claim should be made for rib resection carried out for access purposes.			
3.	When an adrenalectomy is performed in conjunction with a nephrectomy and is incidental to the removal of the kidney, there should be <u>no</u> additional claim for the adrenalectomy.			
Percutaneous Procedures (IOP)				
96802	Percutaneous nephrostomy		153.35	
96804	Insertion of stent		131.22	
96806	Dilation of tract		129.26	
96808	Selective catheterization of calyces		70.99	
96810	Nephroscopy		129.26	
96812	Removal of renal calculi	46.29	226.16	6
96814	- if disintegrated by any method, to 96812		129.26	
96816	- percutaneous removal of staghorn calculus filling renal pelvis and extending into calyces, to 96812		175.50	
Incision				
96820	Renal biopsy, needle (IOP)		143.55	4
96822	Drainage of kidney abscess	64.80	475.00	7
96824	Drainage of perinephric abscess	64.80	475.00	7
96826	Exploration of renal and perirenal tissues with or without biopsy or unroofing of cyst	64.80	207.10	7
Nephrotomy				
96828	- with drainage - nephrostomy	64.80	366.62	7
96832	- with removal of calculus	64.80	482.40	7
96836	Transection of aberrant renal vessels	64.80	226.72	7
96838	Pyelotomy - with drainage	64.80	300.00	7
96840	- with removal of calculus	64.80	437.20	7
96842	- with diversion of urine	64.80	442.78	7
96844	Removal of staghorn calculus filling renal pelvis and calyces- open, with or without x-ray control and/or anatomic nephrolithotomy	64.80	657.75	9
Excision				
96850	Calycectomy with diversion of urine	64.80	512.00	7
96852	Hemi-nephrectomy	64.80	875.00	7
96854	Partial or hemi-nephrectomy with total ureterectomy	64.80	757.85	7
Nephrectomy				
96860	- simple	64.80	650.00	7
96865	- thoraco-abdominal or radical nephrectomy with or without gland dissection	120.34	929.70	13
- with repair of vena cava for thrombus				
96866	- above hepatic vein		236.70	
96867	- below hepatic vein		138.15	
96868	- partial nephrectomy for malignancy	120.34	900.00	13
96872	Nephro-ureterectomy, total	64.80	834.44	10
96874	Nephro-ureterectomy, total, with resection of ureterovesical junction	64.80	900.00	10
96876	Excision of stenosed renal artery with reimplantation or homograft	64.80	414.20	15

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
KIDNEYS AND PERINEPHRUM (Cont'd)				
Repair				
96880	Pyeloplasty	64.80	679.25	7
96884	Nephropexy	64.80	226.72	7
96886	Renal sympathectomy	64.80	257.24	7
96888	Symphysiotomy, for horseshoe kidney with or without nephropexy and associated procedures	64.80	437.20	7
96890	When 96860 or 96865 or 96868 or 96872 or 96880 is performed laparoscopically add 25%			
Note: Fee code 96890 cannot be billed with any code not listed in the definition.				
Suture				
96894	Ruptured or lacerated kidney - repair or removal	64.80	650.00	7
Extra Renal Procedures				
96910	Excision of retroperitoneal tumour	64.80	381.60	7
96912	Exploration of retroperitoneal tumour	64.80	260.85	7
96914	Sacro-coccygeal teratoma	55.54	437.20	6
96916	Renal hypothermia - extra		32.70	
Extracorporeal Shock Wave Lithotripsy (IOP)				
96918	- unilateral, any mode, per session, per patient		366.33	6
96920	- bilateral, any mode, per session, per patient		652.68	6
Kidney Transplants				
96940	Kidney transplant (team fees, these fees <u>do not</u> include immunosuppressive therapy, which is on a fee-for service basis		1,553.15	13
96944	Donor nephrectomy (extra) team fee, uni or bilateral	64.80	1,050.00	16
96948	Renal autotransplantation		1,161.60	10

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
URETER				
Incision				
96970	Peri-ureteral abscess	55.54	130.80	6
	Ureterotomy, abdominal or vaginal exploratory or for drainage			
96972	- upper 2/3	55.54	282.60	6
96974	- lower 1/3	55.54	391.87	6
	with removal of calculus			
96976	- upper 2/3	55.54	376.80	6
96978	- lower 1/3	55.54	482.40	6
	where ureter has been previously opened			
96980	- upper 2/3	55.54	437.20	6
96982	- lower 1/3	55.54	522.50	6
Excision				
	Ureterectomy			
96990	- including ureterovesical junction	64.80	437.20	7
96992	- other	64.80	331.70	7
Repair				
97000	Trimming of ureter	55.54	257.24	6
97002	Uretero-vesical anastomosis or reimplantation - unilateral	55.54	575.43	8
97004	Re-implantation of bifid ureter	55.54	482.40	8
97006	Uretero-ileal conduit	55.54	788.15	9
97008	Uretero-ileal conduit with total cystectomy	55.54	788.15	15
97010	Uretero-ileal conduit with ureterectomy and ileal replacement	55.54	893.50	7
97012	Uretero-intestinal anastomosis or transplant - unilateral	55.54	331.70	6
97018	Uretero-ureterostomy	55.54	552.30	8
97020	Ureterostomy, cutaneous, unilateral	55.54	260.85	6
97024	Uretero-vaginal fistula	55.54	557.85	6
97026	Ureterolysis for periureteral fibrosis - unilateral	55.54	437.20	6
	Note: Fee code 97026 is not payable for identifying and protecting the ureter during abdominal, pelvic or retroperitoneal surgery.			
97028	Ureteroplasty (Hutch), unilateral	55.54	331.70	6
97030	Bladder flap (Boari), includes re-implantation of ureter	55.54	502.45	6
Suture				
	Spontaneous/traumatic rupture or transection			
97040	- immediate - upper 2/3	55.54	381.60	6
97042	- lower 1/3	55.54	437.20	6
97044	- late repair - upper 2/3	55.54	437.20	6
97046	- lower 1/3	55.54	482.40	7
Endoscopic Procedures				
97050	Calibration and/or dilation - 1 or both sides (IOP)		207.26	4
97052	Manipulation and/or removal of calculus including ureteral meatotomy if required		296.90	4
	Cystoscopy and diagnostic ureteroscopy above			
97054	Intramural ureter (IOP)		169.32	4
97056	- with removal of calculus		226.16	
97058	- if disintegrated by ultrasound		129.26	

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
BLADDER				
Endoscopy-Cystoscopy				
Diagnostic Procedures, includes dilation for access (IOP)				
<i>Note: Includes catheterization of ureters with or without collection or ureteral specimens, intravenous function test and retrograde injection of opaque media and/or manometry and/or meatotomy.</i>				
97070	Cystoscopy with or without urethroscopy		95.66	4
97072	Repeat within 30 days		47.83	4
97078	With transurethral biopsy, brush biopsy of renal pelvis and/or ureter			
 add		33.54	
97079	With insertion of ureteral stent	add	134.35	4
97080	With retrograde pyelogram	add	28.00	
97088	With needle biopsy of prostate	add	43.91	
Therapeutic Procedures				
(payable with, add-on to code 97070)				
97090	With electrocoagulation of tumour	add	67.21	
97092	With electrocoagulation of ulcer	add	67.21	
With excision of tumour or tumours including base and adjacent muscles and electrocoagulation if necessary				
97096	- single tumour up to 2 cm. diameter	add	216.00	
97098	- single tumour over 2 cm. diameter	add	300.00	
97100	- multiple tumours	add	300.00	
97102	With resection bladder neck - female	add	134.35	
97104	- male	add	350.88	1
97105	With laser photovaporization of bladder neck - male	add	350.88	
97106	With electro-surgical ureteral meatotomy	add	134.35	
97108	With removal of foreign body or calculus	add	134.35	
97110	With intra-detrusor botulinum toxin injection(s) - one or more	add	75.00	
Introduction (IOP)				
Catheterization				
97120	- office		8.55	
97122	- home		16.25	
	- hospital		VF	
97126	Intravesicular chemotherapy includes catheterization		25.65	
Incision				
97130	Aspiration (IOP)		13.08	
97132	Cystotomy with trocar or cannula and insertion of tube		85.30	5
97136	Incisional cystotomy or cystostomy	46.29	215.80	5
97138	Incisional cystotomy or cystostomy and electrocoagulation of tumour	46.29	194.02	5
97140	Cystolithotomy	46.29	275.00	5
97142	Cutaneous vesicostomy	46.29	231.08	5
97144	Reduction cystoplasty (bladder plication)	46.29	215.80	5

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
BLADDER (Cont'd)				
Excision				
Cystectomy				
97150	Partial for tumour or diverticulum (single or multiple)	55.54	381.60	6
97152	- with reimplantation of ureter	55.54	552.30	7
97154	- with reimplantation of ureters	55.54	733.50	7
97156	Complete cystectomy, without transplant	55.54	657.75	10
97160	Cystectomy with uretero-ileal conduit	74.06	1,600.00	15
97162	Cystectomy with continent diversion	83.31	2,000.00	15
97164	Excision of urachal cyst or sinus with or without umbilical hernia repair	55.54	296.30	6
97166	Excision of urachus, repair of bladder and diversion of urine	55.54	161.32	6
Extrophy				
97168	- excision of bladder and repair of abdominal wall, inclusive of graft	55.54	215.80	6
97174	- plastic repair of extrophy using bladder and including skin flaps	55.54	657.75	6
Repair				
97228	Urinary diversion procedure using intestine, without cystectomy	83.31	1,013.45	15
97230	Repair of ruptured bladder	46.29	330.90	6
97232	Cystoplasty, using intestine	46.29	657.75	9
97234	Suprapubic sphincterectomy for Marion's disease	46.29	194.02	5
Plastic repair of bladder neck				
97236	- child	46.29	331.70	5
97238	- adult or adolescent	46.29	437.20	5
97240	- with diverticulectomy	46.29	493.88	7
Destruction				
97250	Litholapaxy, visual or tactile and removal of fragments	46.29	215.80	4
Suture				
Closure of fistula				
97260	External, suprapubic	37.03	260.85	4
97262	Vesico-vaginal - vaginal approach	37.03	772.40	6
97264	- trans-vesical approach	46.29	467.00	6
97266	Vesico-rectal or vesicosigmoid	46.29	446.90	6

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
URETHRA				
Incision				
97280	Biopsy of urethra without endoscopy (IOP)		23.55	4
97282	Urethrotomy, external	27.77	215.80	4
97288	Urethrostomy	27.77	215.80	4
97290	Meatotomy and plastic repair		31.60	4
97296	Peri-urethral abscess- complete care		32.70	4
Excision				
97300	Caruncle	27.77	85.30	4
97302	Urethral papilloma, single or multiple		85.30	4
	Stricture, including diversion			
97304	- 1 stage	27.77	226.72	4
97306	- 2 stage - first stage	27.77	128.62	4
97308	- second stage	27.77	194.02	4
97310	Diverticulectomy		300.00	4
97312	Posterior urethral valve	37.03	331.70	4
97314	Prolapse urethra, excision		85.30	4
97316	Urethrectomy - radical	37.03	215.80	4
Endoscopy				
97320	Urethroscopy - diagnostic (IOP)		35.50	4
97322	- with biopsy (IOP)		77.70	4
97324	Internal urethrotomy		166.05	4
97326	Removal of foreign body or calculus		170.65	4
Repair				
97330	Urethral sling	27.77	300.00	4
97331	Male sling	27.77	381.60	4
97332	Marshall Marchetti	46.29	293.82	5
97334	Insertion of artificial urinary sphincter	37.03	854.37	6
	Urethroplasty - 1 st stage			
97336	- posterior	37.03	419.76	6
97338	- anterior	37.03	293.35	4
97340	- 2 nd stage	37.03	235.35	4
97342	One stage repair (to include skin graft if necessary)	37.03	381.60	6
97344	Kauffman type procedures for urinary incontinence	27.77	200.56	5
97346	- where perineum has been previously operated on for incontinence ...	27.77	231.08	5
97348	- removal of perineal incontinence prosthesis	27.77	239.75	5
Suture				
97360	Rupture, anterior urethra (diversion of urine, extra)	37.03	170.65	4
97362	Posterior urethra - immediate repair	37.03	437.20	4
97364	- late repair	37.03	552.30	5
Fistula				
97366	- penile urethra (diversion of urine, extra)		92.10	4
97368	- perineal urethra	37.03	325.95	4
97370	- recto-urethral with diversion, colostomy and closure of colostomy	55.54	552.30	7

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
URETHRA (Cont'd)				
Destruction				
97380	Urethro-vesicolysis	27.77	215.80	4
97382	Transurethral incision or resection of external sphincter (when sole operative procedure)		325.95	4
Manipulation (IOP)				
Dilation of stricture, male				
97390	- dilation under local anaesthetic		14.17	
97392	- dilation under general anaesthetic		52.70	4
97394	Dilation of urethra, female		6.54	
97396	- dilation under general anaesthetic		41.65	4

SURGICAL PROCEDURES

OPERATIONS ON THE MALE GENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
PENIS				
Incision				
Slit of prepuce				
97410	- newborn		14.35	
97412	- child or infant		21.50	4
97414	- adult		30.25	4
Excision				
Circumcision - for physical symptomatology only				
97422	- infant		90.05	4
97424	- adult or child		179.40	4
Notes:				
1. Circumcision is an insured service only when medically necessary. As such, circumcision performed for ritual, cultural, religious or cosmetic reasons at any age is not an insured service.				
2. Circumcision for neonatal phimosis is not an insured service.				
97426	Biopsy (IOP)		45.00	4
Amputation				
97428	- partial	37.03	300.00	4
97432	- radical	55.54	450.00	7
Condylomata (IOP)				
97434	- excision under local anaesthetic		32.60	
97436	- excision under general anaesthetic		78.60	4
97438	Excision plaque for Peyronies disease or Nesbitt or modified Nesbitt (graft extra)	37.03	300.00	4
Repair				
Hypospadias or Epispadias				
One Stage Repair				
97441	- with meatus to, but not into glans	55.54	287.75	6
97443	- with advancement of meatus into glans	55.54	383.50	6
97444	- into glans using island flap pedicle (penoscrotal)	55.54	662.45	6
97446	- chordee repair	37.03	215.80	4
97448	Plastic reconstruction, urethra	37.03	331.70	4
97450	Closure urethro-cutaneous fistula	37.03	92.10	4
97452	Insertion of penile prosthesis	37.03	440.00	4
97454	- with inflatable prosthesis		100.00	
97456	Surgical removal of prosthesis	37.03	110.15	4
97460	Intracorporeal injection for impotence (IOP)		27.80	

SURGICAL PROCEDURES

OPERATIONS ON THE MALE GENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
TESTIS				
Incision				
97470	Abscess (IOP)		55.15	4
97472	Biopsy (IOP) - single		55.15	4
97474	- bilateral		83.35	4
97476	- with vasography		120.80	4
97478	Orchidectomy - unilateral	27.77	170.65	4
97480	Radical removal lymph nodes for testicular tumour	55.54	775.00	8
97481	Retroperitoneal lymph node dissection post-chemotherapy	74.06	1,085.00	11
97482	Radical orchidectomy for malignancy - unilateral	27.77	235.35	4
Repair				
97490	Orchidopexy, any type, any stage	37.03	364.80	4
97494	Exploration for undescended testicle, without orchidopexy	37.03	260.85	4
97496	Reduction of torsion of testis or appendix testis and repair	27.77	235.35	4
97498	Ruptured testicle	27.77	170.65	4
97500	Insertion of testicular prosthesis	55.54	170.65	6
Note: Insertion of testicular prosthesis at the time of orchidectomy is not eligible for payment.				
EPIDIDYMISS				
Incision				
97510	Abscess (IOP)		55.15	4
Excision				
97520	Spermatocoele or spermatic granuloma excision	27.77	205.35	4
97522	Epididymectomy - unilateral	27.77	170.65	4
97524	Anastomosis epididymovasostomy	27.77	205.35	4
TUNICA VAGINALIS				
Incision				
97530	Hydrocoele aspiration (IOP)		16.25	
Excision				
97536	Hydrocoele - unilateral	37.03	205.35	4
Note: Hydrocoele excision with hernia repair is claimed as 96728.				

SURGICAL PROCEDURES

OPERATIONS ON THE MALE GENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SCROTUM				
Incision				
97540	Abscess or haematocoele (IOP)		60.00	4
97544	- and exploration - unilateral	27.77	85.30	4
Excision				
97550	Minor lesions, e.g., sebaceous cysts, fibromata, etc.		47.95	4
97552	Resection of scrotum	27.77	136.34	4
Suture				
Note:				
For suture of lacerations, refer to the listings under Operations on the Integumentary System – Suture of Laceration.				
VAS DEFERENS				
Incision				
97560	Vasography (IOP)		55.15	4
Repair				
97564	Anastomosis, unilateral	27.77	215.80	4
97566	- including biopsy and vasography	27.77	260.85	4
Note:				
Reconstruction following previous sterilization procedures is <u>not</u> an insured service.				
Suture				
97580	Ligation - bilateral (IOP)	27.77	126.05	4
SPERMATIC CORD				
Excision				
97590	Hydrocoele - single	27.77	205.35	4
97592	Varicocoele - single	27.77	205.35	4
SEMINAL VESICLES				
Incision				
97600	Abscess (IOP)		120.80	4
Excision				
97606	Vesiculectomy	27.77	552.30	4

SURGICAL PROCEDURES

OPERATIONS ON THE MALE GENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
PROSTATE				
Incision				
97610	Biopsy - needle (IOP)		71.68	4
97611	- with ultrasound guidance		118.80	
97612	- with drainage abscess (IOP)	37.03	73.94	4
97613	- with MRI-US fusion	add	200.00	
97618	Biopsy, perineal, open	37.03	215.80	4
Excision				
97620	Perineal	55.54	650.00	6
97622	Perineal with vesiculectomy	55.54	1,100.00	11
97624	Suprapubic - 1 or 2 stages	46.29	600.75	5
97630	Retropubic - simple	46.29	600.75	5
97632	- radical	46.29	1,100.00	5
97634	Transpubic total prostatovesiculectomy with pelvic lymph node dissection ..	74.06	496.82	11
Notes:				
1. Prostatectomy fees (97620-97634) do not include payment for investigative cystoscopy but do include payment for vasectomy when rendered.				
2. The radical prostatectomy fee (97632) includes payment for plastic repair of bladder neck and/or vesiculectomy when rendered.				
97636	Staging pelvic lymphadenectomy for prostatic cancer	64.80	431.20	7
Notes:				
1. Must include at a minimum bilateral obturator nodes.				
2. A sampling of nodes does not constitute a complete staging lymphadenectomy. When only a sampling of nodes is performed as the sole procedures either 95438 or 96712 may be eligible for payment depending on the procedure performed.				
Endoscopy (Cystoscopy included)				
97640	Transurethral electrosection		489.02	5
97641	Laser photovaporization of prostate		486.78	5
97642	Transurethral drainage of abscess, complete care		85.30	5

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	In composite operations such as repair of cystocele and rectocele and D & C, or cystocele and rectocele and cauterization of cervix and biopsy, the fee shall, unless otherwise mentioned below, be that of the major procedure.			
VULVA				
Incision				
97660	Hymenotomy		32.56	4
	Abscess of vulva, Bartholin or Skene's gland (IOP)			
97662	- local anaesthetic		17.30	
97664	- general anaesthetic		50.90	4
97668	Perineotomy (IOP)		22.45	
Excision				
97674	Hymenectomy (with or without perineotomy)		92.30	4
Vulvectomy				
97676	- simple - partial or total	37.03	257.05	4
97678	- radical			
	- without gland dissection - partial or complete resection	55.54	431.45	6
97680	- with complete dissection of glands - uni or bilateral	55.54	546.75	7
97682	Cyst of Bartholin's gland	27.77	112.00	4
97684	Marsupialization of cyst (IOP)		164.00	4
Condylomata - single or multiple (IOP)				
97686	Chemical -1		5.61	
97688	- 2		8.43	
97690	- 3 or more		11.23	
Surgical excision or electrodesiccation (ED)				
97692	- excision or ED under local anaesthetic		26.85	
97694	- excision or ED under general anaesthetic		115.10	4
97696	Cryosurgery - initial or subsequent treatment		15.00	
Laser destruction of vulval lesions				
97698	- laser destruction under local anaesthetic		22.40	
97700	- laser destruction under general anaesthetic		94.50	4
Repair				
97710	Non-obstetrical injury to vulva and/or vagina, and/or perineum	IC	IC	IC
97712	Ligation of varicose vein of labia - uni or bilateral		44.91	4

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
VAGINA				
Incision				
97720	Colpotomy, posterior, drainage or needle puncture		41.54	4
97722	Culdotomy, incision and exploration	27.77	81.96	4
97724	Culdoscopy including biopsy (IOP)		61.75	4
97726	Incision and drainage of cyst, abscess or haematoma		92.30	4
Excision				
Biopsy(s) - when sole procedure (IOP)				
97730	- biopsy under local anaesthetic		26.85	
97732	- biopsy under general anaesthetic		92.30	4
97734	Local excision of cyst	27.77	123.70	4
97736	Excision of congenital vaginal septum	27.77	281.85	4
97738	Colpectomy, partial or complete, for non-malignant lesions (<u>not</u> to be used to claim for biopsy)	37.03	255.98	6
97740	Colpectomy, radical for malignancy	74.06	480.00	8
97742	Laser treatment of vagina under general anaesthesia		150.00	4
Repair				
97750	Cystocoele or rectocoele	27.77	222.37	5
97752	Cystocoele and rectocoele	27.77	361.77	5
97754	Cystocoele, rectocoele and enterocele	27.77	361.77	5
97756	Rectocoele and enterocele	27.77	341.54	5
97758	Cystocoele, rectocoele and prolapse (Fothergill)	27.77	222.29	5
97760	Cystocoele, rectocoele and excision cervical stump	27.77	349.00	6
97762	Vaginal vault prolapse (post hysterectomy) or enterocele	27.77	407.37	6
97768	Rectocoele and repair of anal sphincter	27.77	272.40	5
97770	Perineorrhaphy	27.77	122.75	4
97772	Colpocleisis	46.29	257.05	5
97774	Operation for artificial vagina	37.03	235.77	6
Closure of fistula				
- vesico-vaginal				
97776	- 1 surgeon	37.03	322.20	6
97778	- 2 surgeons - vaginal surgeon	37.03	196.47	6
97780	- abdominal surgeon		196.47	
97782	- recto-vaginal (any repair)	37.03	366.07	6
97784	- uretero-vaginal	55.54	280.68	6
97786	- urethro-vaginal	37.03	129.11	4
97788	Urethral caruncle or prolapse of mucosa		59.50	4
97790	Retropubic urethropexy for stress incontinence	37.03	301.35	5
Combined abdominal - vaginal procedure for stress incontinence				
97794	- 1 surgeon	55.54	725.32	7
97796	- 2 surgeons - vaginal surgeon	55.54	123.50	7
97798	- abdominal surgeon		215.56	
Manipulation				
97808	Examination and/or dilation - vagina - general anaesthetic (IOP)		28.07	4

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
FALLOPIAN TUBE				
Excision (unilateral or bilateral)				
97820	Salpingectomy and salpingo - oophorectomy	55.54	365.22	6
97822	Partial salpingectomy for sterilization	55.54	189.66	6
Repair				
Tubal plastic operation				
97830	- fimbriolysis - unilateral	55.54	213.29	6
97832	- salpingostomy - unilateral	55.54	278.93	6
97834	- resection with reanastomosis	55.54	288.83	6
97838	Repair of extensive tubal and peritubal disease using operating microscope (not to be charged for reconstruction following previous sterilization procedures) uni or bilateral)	74.06	567.97	8
Suture				
97844	Ligation of tubes, all methods, all approaches	55.54	235.95	6
OVARY				
Excision (uni or bilateral)				
97850	Biopsy of ovaries by laparotomy	46.29	315.42	6
97852	Wedge resection of ovaries (e.g. Stein-Leventhal)	46.29	257.05	6
97854	Oophorectomy	55.54	364.27	6
97856	Oophorectomy with omentectomy for malignant disease	55.54	468.77	6
97858	Oophorocystectomy	55.54	364.27	6
97860	Para ovarian cyst	55.54	364.27	6
97862	Oophorectomy with or without omentectomy for malignant disease and with pelvic and/or perioaortic Lymphadenectomy	55.54	943.22	6
97864	Second look exploratory laparotomy including biopsies, when done as part of chemotherapy protocol for ovarian carcinoma with or without total omentectomy	55.54	431.45	6
97866	Culdectomy (extensive removal of pelvic peritoneum required for evacuation of malignancy extension of secondaries)	55.54	200.00	6
UTERUS AND CERVIX UTERI				
Endoscopy (IOP)				
97870	Colpomicroscopy (includes vagina)		49.12	4
97872	- with biopsy and/or endocervical curettage		65.50	4
97874	Hysteroscopy		138.04	
97876	- with biopsy		155.29	
97878	- with cannulization of tubes		163.57	

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
UTERUS AND CERVIX UTERI (Cont'd)				
Incision				
97890	Endometrial biopsy (IOP)		34.05	
97892	Biopsy, cervix (IOP)		20.00	4
97910	Hysterotomy	55.54	185.25	6
97914	Cryoconization, electroconization with or without endocervical curettage (IOP)		59.51	4
97916	CO ₂ laser therapy with or without curettage for CIN (Cervical Intra-epithelial Neoplasia) (IOP)		79.22	4
Excision				
<i>NOTE: D & Cs are <u>not</u> billable in addition to code 97926 or 97928.</i>				
Diagnostic curettage				
97920	- (with or without cauterization biopsy of cervix, removal of polypi or Rubin's test) (IOP)		92.30	4
97922	- and hystero-salpingography (IOP)		92.30	4
97924	- with knife conization of cervix (includes <u>additional</u> biopsies)	27.77	200.73	4
Therapeutic hysteroscopy/endometrial ablation				
97926	- initial		234.58	6
97928	- repeat procedure within 1 year		145.00	6
Hysterectomy (with or without adnexa or enterochoele)				
97930	Total, abdominal or vaginal	55.54	521.37	6
97932	- with cystochoele and rectochoele	55.54	581.92	6
97934	- with cystochoele or rectochoele	55.54	551.65	6
97938	Partial or subtotal	55.54	361.70	6
97940	- with cystochoele and rectochoele	55.54	407.72	6
97942	- with cystochoele or rectochoele	55.54	377.45	6
97948	Radical (total hysterectomy plus lymphadenectomy)	74.06	797.04	8
97950	Myomectomy	55.54	442.27	6
97952	Amputation of cervix	37.03	173.55	4
97954	Cervical stump - abdominal	55.54	321.90	6
97956	- vaginal	37.03	321.90	4
Introduction (IOP)				
97960	Insufflation - Rubin's test		26.94	4
97962	Insufflation and endometrial biopsy		43.19	4
97964	Insertion of IUCD		35.00	
Repair				
97970	Hysteropexy (uterine suspension)	55.54	204.32	6
97972	- with anterior and posterior repair	55.54	294.14	6
97974	- with anterior or posterior repair	55.54	267.19	6
97976	Cervix, incompetent	27.77	80.83	4
97978	Trachelorrhaphy (plastic repair of cervix) – not immediately following delivery	27.77	61.75	4
97982	Hysteroplasty - excision of septum (Strassman)	55.54	196.47	6
97984	Unification of double uteri	37.03	255.98	4
97986	Uterine inversion - manual		95.43	4
97988	- operative	37.03	196.47	6
97990	Presacral neurectomy	55.54	196.47	6

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Assist	FP/ Spec.	Anaes.
UTERUS AND CERVIX UTERI (Cont'd)			
Cautery of Cervix (IOP)			
Office			
97994		VF	
		4.49	
97996		26.94	4

SURGICAL PROCEDURES
OPERATIONS ON THE ENDOCRINE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
THYROID GLAND				
Incision				
98010	Aspiration, thyroid cyst (IOP)		38.00	
98012	Biopsy, needle (IOP)		71.30	6
98014	Abscess, complete care		70.85	4
Excision				
Biopsy				
98020	- surgical	55.54	213.15	6
Thyroidectomy				
98022	- total	55.54	777.30	8
98024	- subtotal	55.54	618.25	7
98026	- hemi	55.54	525.15	7
98027	- parathyroid(s) re-implantation add		184.60	
Note:				
Fee code 98027 can be billed in addition to fee codes 98022, 98024 or 98026.				
98028	Excision of solitary nodule	55.54	289.10	6
PARATHYROID, THYMUS AND ADRENAL GLANDS				
Excision				
98040	Exploration and/or removal, parathyroids or parathyroid tumour	55.54	605.45	8
98042	- if requiring splitting of sternum	120.34	632.46	13
98044	Thymectomy	120.34	689.38	13
98046	Adrenalectomy or exploration, unilateral	92.57	646.30	10
98048	- bilateral, with or without oophorectomy	92.57	1,032.70	11
98050	Pheochromocytoma	111.08	871.80	13
98052	Thymus transplant (IOP)		44.69	4

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
98100	Hypothermia - when employed, basic fee for <u>any</u> procedure on nervous system			25
BRAIN				
Astrocytoma, oligodendroglioma, glioblastoma or metastatic tumour				
Craniotomy plus excision				
98130	- supratentorial	101.83	1,562.90	15
98132	- infratentorial	101.83	1,726.80	15
98134	Craniotomy plus lobectomy	101.83	1,575.80	15
98136	Microsurgical removal		237.36	
Meningioma and other tumourous lesions				
Craniotomy plus excision				
98138	- supratentorial	101.83	2,072.16	15
98140	- infratentorial plus basal	101.83	2,305.62	15
98142	- microsurgical removal		237.36	
98144	- lesion greater than 4 cm. diameter		454.15	
98146	- team fee for acoustic neuroma		627.65	
Intracranial aneurysm repair				
98150	- carotid circulation	101.83	2,568.18	15
98152	- vertebrobasilar circulation (including aneurysm of vein of Galen)	101.83	2,140.15	15
98154	- microsurgical approach		237.36	
Cerebral arteriovenous malformation				
Craniotomy for obliteration and/or excision				
98156	- supratentorial	101.83	1,953.14	15
98158	- infratentorial	101.83	1,532.10	15
98160	- microsurgical approach		237.36	
98164	Extracranial approach to include balloon catheter or embolization techniques	101.83	873.53	15
Extracranial-intracranial microvascular anastomosis				
98168	- superficial temporal artery	101.83	1,203.09	15
98170	- occipital artery	101.83	1,255.30	15
98174	- use of graft (autogenous vessel or synthetic)		246.00	
Carotid-cavernous fistula				
98178	- intracranial obliteration (to include combined cervical and intracranial procedure)	101.83	1,254.85	15
98180	- extracranial approach	101.83	763.30	15
Spontaneous Intracerebral Haemorrhage				
Craniotomy plus removal				
98182	- supratentorial	101.83	1,262.13	15
98184	- infratentorial	101.83	1,385.05	15
98186	Burr hole plus drainage	101.83	531.37	15

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
BRAIN (Cont'd)				
Intracranial Cyst				
	Craniotomy plus evacuation, to include interventriculostomy			
98188	- supratentorial	101.83	899.87	15
98190	- infratentorial	101.83	1,065.05	15
98192	Burr hole plus aspiration	101.83	426.95	15
Brain Abscess				
98194	- craniotomy and excision	101.83	1,416.50	15
98196	- burr hole and aspiration	64.80	587.87	7
98198	- subsequent aspiration through existing burr hole within 30 days	64.80	237.36	7
Miscellaneous Procedures				
98200	Craniotomy for brain biopsy (other than for tumour)	101.83	774.90	11
98202	Hemispherectomy	101.83	1,878.35	15
98204	Temporal lobectomy and/or excision of cortical scar for epilepsy	101.83	2,184.20	15
98210	Craniotomy plus midline commissurotomy	101.83	1,035.40	15
98212	Repair of encephalocele	101.83	798.80	15
98216	Posterior fossa decompression for Arnold Chiari malformation	101.83	1,500.00	15
98222	Stereotaxis - intracranial, to include ventriculography	101.83	1,377.58	11
98224	Replacement of deep brain stimulation (DBS) system – Neurostimulator module		510.00	5
98232	Burr hole plus needling of brain for biopsy (IOP)	64.80	453.60	7
98234	Ventriculogram, includes burr holes, air or positive contrast (IOP)		192.06	7
98236	Ventricular puncture through previous burr hole or fontanelle, or puncture and/or aspiration of cisterna magna (IOP)		90.49	7
98238	Ventriculotomy, to include burr hole (IOP)		408.95	7
98242	- with interventriculostomy		301.70	
98244	External ventricular drainage (IOP)	46.29	237.36	5
98250	Insertion of intracranial catheter or transducer for purposes of monitoring (IOP)	46.29	350.45	5
98252	Subsequent revisions or replacements within 30 days (IOP) - each	46.29	279.55	5
98254	Re-opening of craniotomy for post-operative haematoma or infection, or for removal of bone flap	101.83	496.89	11
98256	Intracranial duraplasty (greater than 2 cm. diameter) to any intracranial procedure		265.67	
98260	Intra-operative electrophysiological monitoring and/or stimulation		222.64	
98262	Repeat craniotomy (excluding 98254), add to benefit for above surgery involving craniotomy		252.20	
98264	Stereotactic radiosurgery - per patient, per course of treatment		1,522.60	11

Note:

The fee for code 98264 represents payment to a neurosurgeon for the following services provided in hospital to a patient for whom stereotactic radiosurgery has been prescribed:

- i. participation in multidisciplinary clinics;
- ii. mapping and merging the patient care plan with the health professionals involved in the procedure;
- iii. attendance during the administration of the radiosurgery;
- iv. application of halo frame if required.

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
BRAIN (Cont'd)				
Cranio-Cerebral Injuries				
	Reduction of skull fracture			
98272	- simple, depressed	64.80	634.90	7
98274	- compound	101.83	773.15	11
98276	- with repair of dural laceration add		233.30	4
	Extracerebral haematoma			
98278	- drainage of burr hole(s) - unilateral	64.80	595.70	7
98280	- drainage and/or removal by craniotomy	101.83	933.78	11
Cerebral Injury				
98290	Removal of intracerebral haematoma and/or debridement of traumatized brain (includes management of any skull fracture)	101.83	1,040.65	15
98292	Removal of foreign body from brain	101.83	971.86	15
98294	CSF leak - intracranial repair	101.83	1,069.90	15
98296	Decompressive craniectomy (frontal, sub-temporal)	101.83	638.05	11
98298	Subdural tap(s) - unilateral (IOP)		58.60	
98300	Diagnostic burr hole(s), uni or bilateral (IOP)		272.10	7
SKULL				
	Repair of skull defect:			
98310	- acrylic or metal cranioplasty	101.83	677.12	11
98314	- replacement of bone flap	101.83	484.25	11
98316	Skull tumour, excision	101.83	412.18	11
	Craniosynostosis			
	Linear Craniectomy			
98318	- 1 suture	101.83	474.97	11
98320	- multiple sutures	101.83	621.36	15
	Morcellation procedure			
98322	- 1 suture	101.83	476.40	11
98324	- multiple sutures	101.83	750.64	15
	Lateral canthal advancement			
	- unilateral			
98326	- 1 surgeon	101.83	767.86	15
98328	- 2 surgeons - major portion of surgery	101.83	439.79	15
98330	- lesser portion of surgery		355.43	
	- bilateral			
98332	- 1 surgeon	101.83	972.48	15
98334	- 2 surgeons - major portion of surgery	101.83	627.65	15
98336	- lesser portion of surgery		470.79	
98338	Craniotomy for craniofacial repair	101.83	1,087.27	15
98340	- with repair of frontonasal encephalocoele add		219.79	

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
ORBIT				
	Craniotomy			
98350	- plus removal of orbital tumour	101.83	1,139.94	15
98352	- plus orbital decompression (roof of orbit with or without lateral wall) ...	101.83	1,066.53	15
98354	- for decompression of optic nerve(s)	101.83	1,139.94	15
PITUITARY				
98360	Hypophysectomy or excision of tumour, any technique except transphenoidal	101.83	2,000.00	15
98362	Hypophysectomy, transphenoidal, team fee	101.83	2,000.00	15
CAROTID AND VERTEBRAL ARTERIES				
98372	Temporal artery - biopsy, ligation or crysurgery (IOP)		200.00	4
98374	Carotid endarterectomy - with or without bypass	92.57	465.50	10
98378	- with patch or graft	92.57	471.21	10
98380	Progressive carotid occlusion by Selverstone clamp (IOP)	92.57	284.65	10
CSF SHUNTING PROCEDURES				
98409	CSF shunting procedures - all types	101.83	737.00	11
	Revision of CSF Shunt			
98411	- operative - all types	101.83	420.70	7
98413	- non-operative		51.50	
	Conversion of shunt (e.g. ventriculoperitoneal to ventriculoatrial)			
98415	- includes removal of existing shunt	101.83	420.30	7
98416	Removal of shunt - any type	101.83	289.70	7
98420	Insertion CSF reservoir (Ommaya including burr holes)	101.83	370.50	11
98422	Third ventriculostomy	101.83	777.80	11
CRANIAL NERVES				
98430	Percutaneous coagulation of gasserian (trigeminal) ganglion or root - unilateral	101.83	504.95	11
98432	Decompression gasserian ganglion	101.83	481.90	11
	Rhizotomy or differential section trigeminal nerve			
98434	- temporal approach	101.83	473.70	11
98436	- posterior fossa approach	101.83	1,021.89	11
98438	- avulsion supraorbital nerve	37.03	168.20	4
98440	- avulsion infraorbital nerve	37.03	168.20	4
98442	- avulsion mandibular nerve	37.03	195.34	4

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
CRANIAL NERVES (Cont'd)				
98446	Anastomosis hypoglossal to facial nerve	55.54	727.80	6
98450	Occipital and/or suboccipital craniectomy for compression, decompression or section of cranial nerves	101.83	1,478.82	11
98452	Division vestibular nerve	101.83	946.19	11
98454	Division of glossopharyngeal nerve	55.54	946.19	6
98456	Division of nerves to sternomastoid in neck	55.54	305.60	6
PERIPHERAL NERVES				
98470	Biopsy and/or avulsion of peripheral nerve (IOP)	27.77	109.95	4
	Brachial plexus exploration			
98472	- in posterior triangle	55.54	377.95	6
98474	- in axilla	55.54	384.54	6
98476	- in posterior triangle and axilla	55.54	520.12	6
98478	Decompression by scalenotomy	55.54	235.60	6
98480	- excision of cervical rib	92.57	428.01	6
98482	Exploration of major nerve (median, ulna, radial, sciatic, etc.) with or without neurolysis	37.03	191.62	6
98484	Removal tumour major peripheral nerve	37.03	317.85	4
	Suture of major peripheral nerve			
98486	- epineural repair	37.03	500.00	4
98488	- fascicular technique, first fascicle	37.03	325.56	4
98490	- each additional fascicle repaired		54.98	
	Graft of major peripheral nerve			
98492	- epineural grafting	37.03	445.50	4
98494	- fascicular grafting, first fascicle	37.03	927.55	4
98496	- each additional fascicle grafted		109.95	
	Suture or decompression of small peripheral nerve (e.g., digital)			
98498	- epineural technique	27.77	250.00	4
98500	- fascicular repair, first fascicle. Use fee code 98490 to claim for additional fascicles repaired		71.40	
	Graft of small peripheral nerve			
98502	- epineural technique	27.77	99.95	4
98504	- fascicular technique, including first fascicle. Use fee code 98496 to claim additional fascicles grafted		109.95	
98506	Delayed repair or graft (more than 4 weeks from date of injury)		105.66	
98508	Microsurgical technique used		254.00	
98510	Decompression median nerve at wrist	27.77	191.62	4
98512	Decompression ulnar nerve at elbow	27.77	215.35	4
98514	Transposition of ulnar nerve at elbow	27.77	235.60	4
98516	Decompression lateral femoral cutaneous nerve	37.03	139.93	4
98518	Division obturator nerve	55.54	235.60	6
98520	Morton's neuroma - excision	37.03	157.07	4
98522	Excision of glomus tumour (IOP)		109.95	4
98524	Neuroma - single, subcutaneous (IOP)		109.95	4
Implantation or Replacement of Peripheral Neurostimulator				
98528	Implantation of electrode for peripheral nerve stimulation (IOP)	27.77	104.24	4
98530	Vagal nerve stimulator implantation	55.54	460.00	7
98531	Vagal nerve stimulator battery change	55.54	230.00	7

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
AUTONOMIC NERVOUS SYSTEM				
	Sympathectomy			
98540	Cervical	55.54	314.14	6
98542	Cervicodorsal - unilateral	92.57	314.14	10
98546	- thoracic approach	120.34	314.14	13
98548	Lumbar - unilateral	55.54	279.87	6
98550	- bilateral	55.54	414.09	6
SPINAL CORD AND NERVE ROOTS				
	For operations on the spinal cord and nerve roots, the basic Assistants' and Anaesthesiologists' fees will depend on the surgical approach			
98570	- cervical	74.06		10
98572	- dorsal or lumbar	64.80		8
	Tumours - partial or total			
98580	- extradural		980.43	
98582	- intradural (extramedullary)		1,530.00	
98584	- 3 segments or more		175.74	
	Intramedullary			
98590	- biopsy and/or decompression		451.48	9
98592	- removal		1,765.75	12
98594	- 3 segments or more		192.88	
98596	- with operating microscope (applies to intradural or intramedullary tumours)		262.81	
	AV malformation of cord			
98604	Excision or operative obliteration with or without evacuation of haematoma		1,563.52	
98606	- 3 segments or more		192.88	
98608	- with operating microscope		262.81	
98612	Insertion/revision of implantable infusion pump		510.00	
98616	Implantation of permanent subcutaneous reservoir including laminectomy		510.00	
	Note:			
	98616 is not eligible for payment when rendered with any decompressive codes.			
98626	Laminectomy for intradural neurolysis or unusual lesions, e.g., diastematomyelia, tethered conus, intramedullary haematoma etc. – uni or bilateral		976.41	
98628	- laminectomy extending over 3 segments or more (applies to tethered conus, diastematomyelia extradural, intradural or intramedullary tumour, AVM, or other decompressive laminectomy)		192.88	
98630	- with operating microscope		262.81	

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
SPINAL CORD AND NERVE ROOTS (Cont'd)				
	Laminectomy and decompression of spinal cord			
98632	- no opening of dura		432.55	
98634	- with opening of dura (with or without dentate ligament section) no tumour		594.75	
	With fusion by same surgeon			
98638	- 1 level (payable in addition to fee codes above)		264.93	
98640	- 2 levels or more (payable in addition to fee codes above)		333.41	
	Fusion by separate surgeon			
98644	- 1 level		353.24	
98646	- 2 or more levels		410.91	
98648	Refusion of any of above		219.87	
98650	Re-opening of laminectomy for post-op haematoma, infection or CSF leak		201.85	
98656	Medullary spinal trigeminal tractotomy		1,146.55	
98658	- with operating microscope	add	243.35	
98664	Percutaneous cordotomy or tractotomy		594.75	
98668	Open myelotomy for lesion (e.g., tractotomy, midline commissurotomy, Bischoff's longitudinal myelotomy, etc.) – uni or bilateral		1,175.17	
98676	Spinal intradural anterior and/or posterior rhizotomy – uni or bilateral, any number of roots		787.62	
98678	- 3 segments or more	add	192.88	
98679	- with operating microscope	add	262.81	
98680	Repair of meningocele		583.93	
	Repair of meningomyelocele			
98682	- 1 surgeon		700.70	
	- 2 surgeons			
98684	- neurosurgeon		460.19	
98686	- reconstructive surgeon		309.84	
98688	Lumbar puncture (IOP)		75.00	
98690	- with instillation of medication (IOP)		88.03	
	Radiofrequency ablation/Rhizotomy (IOP)			
98700	- vertebral facet or sacral lateral branch neurotomy, first site		128.37	4
98702	- each additional site (to a max. of 4 additional sites)	add	83.96	
98704	Interpretation of CSF smear in malignancy (IOP)		25.18	

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES
OPERATIONS ON THE EYE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
98800	Examination and unlisted minor procedures under general anaesthetic, when <u>sole</u> procedure (IOP)		101.12	4
EYEBALL				
Excision				
98810	Enucleation, donor eye, post-mortem (1 or both)		131.25	
Repair				
98820	Removal of intraocular foreign body	37.03	572.54	6
98822	- non-magnetic-posterior segment	37.03	584.65	6
Penetrating wound				
98824	- with prolapse of intraocular tissue	37.03	640.00	6
98826	- without prolapse of intraocular tissue	37.03	496.00	6
CORNEA				
Incision				
98830	Paracentesis (IOP)		70.00	4
	Removal embedded foreign body (IOP)			
Note:				
<u>Not</u> to be claimed for the routine removal of sutures within 42 days of procedure.				
98832	- removal under local anaesthetic - 1 foreign body		42.93	
98834	- 2 or more foreign bodies		50.00	
98836	- removal under general anaesthetic		74.20	4
Chelation of band keratopathy with EDTA (IOP)				
98838	- chelation under local anaesthetic		37.08	
98840	- chelation under general anaesthetic		72.82	4
Excision				
98850	Pterygium - simple (unilateral)		175.00	4
98852	- with partial keratectomy	37.03	372.50	4
98854	- with lamellar graft	37.03	453.00	8
98856	- with autogenous conjunctival transplant		100.00	
98858	- with mucous membrane graft		113.20	
98860	Keratectomy	37.03	303.68	4
98861	Phototherapeutic Keratectomy		306.93	
Note:				
Prior approval from MCP is required.				
Excision of dermoid				
98862	- with partial keratectomy		303.68	4
98864	- with lamellar graft	37.03	542.00	8
Cauterization of ulcer (IOP)				
98866	- local anaesthetic		25.75	
98868	- general anaesthetic		72.82	4

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES
OPERATIONS ON THE EYE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
CORNEA (Cont'd)				
Replacement				
	Corneal transplant			
98880	- penetrating	37.03	740.00	8
98882	- with artificial prosthesis add		52.40	
98884	- lamellar	37.03	590.00	8
98886	Division of iris to cornea		161.75	4
SCLERA				
Incision				
98890	Sclerotomy, posterior		166.45	4
98892	Anterior chamber - open evacuation of clot	37.03	363.40	6
IRIS AND CILIARY BODY				
98900	Laser iridotomy	37.03	252.97	4
98902	Laser angle surgery		390.88	4
98904	Iridectomy - surgical - when sole procedure	37.03	308.30	4
98906	Glaucoma filtering procedures	37.03	1,133.89	6
98908	- with intraocular implant of seton add		156.16	
98910	Extraocular glaucoma procedures	37.03	182.75	4
98912	Ciliary body reattachment	37.03	505.45	8
CRYSTALLINE LENS				
Incision				
98920	Needling (discission) - primary or subsequent		161.75	5
98922	Capsulotomy (any method)	37.03	285.58	4
Excision				
Cataract				
98930	- all types of, by any procedure	37.03	473.09	8
98932	- dislocated lens extraction	37.03	597.98	6
98934	- insertion of intraocular lens add		101.38	
98936	Fixation of intraocular lens (McCannell suture procedure)	37.03	263.76	6
98938	Excision of secondary membrane with corneal section following cataract extraction	37.03	259.05	6
98940	Removal of intraocular lens	37.03	309.31	6
98942	Repositioning, surgical of dislocated intraocular lens		158.93	4
98946	Insertion of secondary intraocular lens	37.03	303.68	8

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES
OPERATIONS ON THE EYE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
VITREOUS				
98950	Vitrectomy by infusion suction cutter technique	37.03	1,264.79	8
98952	- with transscleral retinal suturing add		213.20	
98954	Vitreous aspiration, posterior with needle for culture and/or injection of medication, with or without cryopexy	37.03	232.90	5
98956	Anterior vitrectomy (planned) when done in conjunction with another intraocular procedure add		105.00	
98958	Preretinal membrane peeling or segmentation to include posterior vitrectomy and coagulation	37.03	1,724.39	8
98960	Vitreous exchange (air, gas or artificial vitreous substance) - add to vitrectomy		120.31	
RETINA				
98970	Reattachment of retina and choroid by diathermy, photocoagulation or cryopexy as initial procedure	55.54	459.55	6
98972	Scleral resection or buckling procedure with or without diathermy, photocoagulation or cryopexy, primary or subsequent procedure	55.54	1,554.70	6
98974	Secondary operation following unsuccessful operation or fresh detachment in the same eye by a different surgeon with or without diathermy, photocoagulation or cryopexy	55.54	1,123.80	6
98976	Removal of scleral implant		255.07	4
98978	Photocoagulation - 1 eye		297.20	6
98980	Cryopexy - extraocular or subconjunctival - 1 eye		216.03	6
98982	Pneumatic retinopexy		472.50	6
98984	Laser retinopexy for Retinopathy of Prematurity - one eye		750.00	6
98986	Laser retinopexy for Retinopathy of Prematurity - both eyes		1,245.00	6
	Note: Fee codes 98984 and 98986 cannot be billed for procedures performed on the same day as the Premature Infants Ophthalmology Clinic.			
EXTRAOCULAR MUSCLES				
Repair				
Strabismus procedures				
98990	- 1 muscle, 1 or both eyes	27.77	369.00	5
98992	- 2 muscles, 1 or both eyes	27.77	460.00	5
98994	- 3 or more muscles, 1 or both eyes	27.77	542.00	5
98996	- for adjustable suture add		100.00	
98998	Repeat strabismus procedure (more than 2 previous repairs by different surgeon) add		175.00	

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES
OPERATIONS ON THE EYE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
ORBIT				
Incision				
99010	Drainage of abscess		350.00	6
Excision				
99020	Enucleation, with or without primary implant	37.03	677.50	4
99022	Evisceration, with or without primary implant	37.03	542.00	4
99024	Exenteration	37.03	1,005.00	6
99026	- with major plastic repair		296.90	add
99028	Secondary orbital implant	37.03	640.00	4
99030	Tumour or foreign body - anterior route	37.03	450.00	6
99032	- posterior exposure	37.03	640.00	6
99034	Biopsy - anterior		200.00	4
99036	- posterior exposure		308.30	4
99038	Lateral orbitotomy (Kronlein)	27.77	590.00	6
99040	Decompression - 2 walls	37.03	542.00	6
99042	- 3 walls	37.03	575.85	6
Reconstruction				
99050	Dermis fat graft - immediately following enucleation		190.30	
99052	- delayed	37.03	514.80	6
99054	Fornix reconstruction		325.00	4
99056	- with mucous membrane graft		321.60	4
99058	- with autogenous conjunctival transplant		100.00	add
Free mucous membrane graft				
99060	- full thickness		222.65	4
99062	- split thickness		296.90	4
99064	Alloplastic volume replacement		411.20	4
EYELIDS				
Incision				
Drainage of abscess (IOP)				
99070	- drainage under local anaesthetic		60.00	
99072	- drainage under general anaesthetic		225.00	4
Excision				
Verrucae, papilloma, keratosis, etc. (IOP) - see Skin and Subcutaneous Tissue-Integumentary System also Lid Tumours or Unlisted Plastic Procedures				
Chalazion - single or multiple (IOP)				
99080	- excision under local anaesthetic		70.00	
99082	- excision under general anaesthetic		150.00	4
Epilation				
99084	- by hyfrecator, electrolysis (IOP)		26.60	4
99086	- by cryopexy		64.91	4

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES
OPERATIONS ON THE EYE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
EYELIDS (Cont'd)				
Suture				
99090	Tarsorrhaphy		150.00	4
99092	Double adhesion		161.75	4
Repair				
99100	Ptosis	37.03	313.15	4
99102	- repeat or second repair	37.03	393.00	6
99104	Distichiasis - unilateral	37.03	289.00	4
99106	Trichiasis, repair by tarsal transplantation	37.03	241.70	4
99108	Entropion, other than Zeigler puncture	37.03	301.21	4
99110	- repeat by second surgeon		52.40	
99112	- with mucous membrane graft		113.20	
99114	Ectropion, other than Zeigler puncture	37.03	310.00	4
99116	- repeat by second surgeon		52.40	
	- with skin graft, see Plastic Surgery Procedures -Integumentary System			
99120	Zeigler punctures (for entropion/ectropion) (IOP)		26.60	4
99122	Laceration - full thickness		225.00	4
99124	- including lid margin		300.00	4
99126	Laceration of eyelid including levator palpebrae superioris with ptosis	37.03	329.30	4
Blepharoplasty				
99128	- excision of skin, with/without partial excision of the orbicularis oculi muscle - 1 lid		82.80	4
99130	- plus removal of orbital fat and/or lid fold reconstruction - 1 lid	37.03	298.43	4
99132	Lid lengthening procedure	37.03	288.35	4
99134	- with scleral graft		80.90	
99136	Primary closure of full thickness lid defect	37.03	290.00	4
99138	- with cantholysis		53.20	
99140	- with releasing rotation flap including cantholysis		87.63	
99142	Transconjunctival flap and skin graft (Hughes)	37.03	484.35	6
99144	- second stage		108.45	4
99146	Lower or upper eyelid bridge flap	37.03	484.35	6
99148	- second stage		108.45	4
99150	Temporal rotation flap	37.03	514.80	6
99152	- with free posterior lamellar graft		175.15	
99154	Free tarsal, scleral or cartilage graft with local skin mobilization	55.54	535.80	8
99156	Free composite eyelid graft	55.54	535.80	8
99158	Medial canthoplasty (skin and muscle)	37.03	253.49	4
Medial canthal tendon				
99160	- tendon repair only	37.03	267.35	4
99162	- fixating to bone	37.03	405.60	6
99164	- when done in conjunction with another procedure		153.25	
Lateral canthal surgery				
99166	Canthotomy - <u>not</u> to be claimed with 98930, 98932		51.45	4
99168	Cantholysis - when primary procedure		105.70	4
99170	Lateral canthopexy		200.14	4
99172	- when done in conjunction with another procedure		102.35	
Introduction				
99188	Insertion of gold weight(s) for facial nerve paralysis		81.58	4

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES
OPERATIONS ON THE EYE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
CONJUNCTIVA				
	Removal of foreign body		VF	
Excision				
99190	Peritomy (Gunderson conjunctival flap)		157.81	4
99192	Biopsy (IOP)		26.60	4
Repair				
99200	Excision of conjunctival lesion		100.00	4
99202	- with mucous membrane graft		113.20	add
99204	- with autogenous conjunctival transplant		100.00	add
LACRIMAL TRACT				
Incision				
99210	Dacryocystotomy - general anaesthetic (IOP)		51.55	4
99212	Three "Snip" punctum procedure (IOP)		65.70	4
Excision				
99220	Dacryocystectomy	37.03	250.89	4
Repair				
99230	Lacerated canaliculus - immediate repair	37.03	350.00	4
99232	- delayed repair	37.03	411.20	5
99234	Dacryocystorhinostomy	46.29	542.88	5
99236	- repeat procedure by second surgeon		85.90	add
99238	- with lacrimal by-pass procedure (e.g., Lester Jones) or canalicular reconstruction		79.52	add
99240	Lacrimal by-pass procedure (e.g., Lester Jones) - when sole procedure		178.73	4
Manipulation (IOP)				
99250	Irrigation of nasolacrimal system - uni or bilateral		27.00	
	Probing and dilation of duct - initial or repeat			
99252	- probing and dilation under local anaesthetic - unilateral		27.00	
99254	- probing and dilation under general anaesthetic - uni or bilateral		79.52	4
99256	- with insertion of inlying tube or filament		158.06	4
99258	Reinsertion of Lester Jones tube		51.55	4

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES
OPERATIONS ON THE EAR

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
EXTERNAL EAR				
Endoscopy				
	Removal of foreign body			
	- simple		VF	
99302	- complicated - general anaesthetic, when sole procedure (IOP)		50.90	4
99304	- post auricular approach		125.35	4
99306	- from middle ear space		125.35	4
99308	Removal of drainage tubes under general anaesthesia (IOP)		66.50	4
99310	Debridement of ear(s) under microscopy (IOP)		25.55	
99312	- under general anaesthesia (IOP)		48.45	4
Note: "Debridement of ears" may <u>only</u> be claimed for removal of impacted cerumen by means other than syringing, or suction, or for the therapeutic removal of debris resulting from infection.				
Incision				
99320	Biopsy, ear canal (IOP)		24.60	4
99326	Limited incision for perichondritis, removal of cartilage and drainage		155.30	4
99328	Radical surgery for perichondritis		167.86	5
Excision				
99330	Local excision polyp - office (IOP)		24.60	
99332	- hospital (IOP)		48.45	4
99338	Amputation - partial		83.93	4
99340	- complete		106.82	4
99342	Exostosis, simple endomeatal surgery and removal and drilling out of exostosis		243.35	4
99344	- with multiple removal, with necessary grafting		235.40	4
99346	- posterior auricular approach		171.13	5
99348	Pre-auricular sinus (IOP)		59.60	
99350	- requiring general anaesthetic		208.05	5
Repair				
Microtia				
99360	- minor repair	46.29	269.11	5
99362	- major repair or first stage of a major repair	46.29	345.15	5
99364	- subsequent stages of a major repair (maximum of 2 subsequent stages)	46.29	269.11	5
99366	Congenital atresia of canal, includes necessary mastoid surgery	46.29	348.80	5
99368	Otoplasty for correction of outstanding ears - unilateral	46.29	247.35	5
Note: Otoplasty for correction of outstanding ears is insured for patients 0-17 years of age. It is not an insured service for patients 18 years of age and older.				
99372	Meatoplasty or canalplasty for congenital malformation	46.29	290.16	5
99374	- with grafting of canal		197.54	1
99376	- with tympanoplasty and/or ossiculoplasty and/or mastoidectomy		390.31	2

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES
OPERATIONS ON THE EAR

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
MIDDLE EAR				
Introduction (IOP)				
Eustachian Catheterization				
99380	- catheterization under local anaesthetic - unilateral		5.45	
99382	- catheterization under general anaesthetic - uni or bilateral		21.80	4
	Insufflation of eustachian tube		VF	
99383	Intratympanic injections		150.00	
Incision (IOP)				
Myringotomy, to include aspiration when indicated				
99390	- myringotomy under local anaesthetic		42.15	
99392	- with insertion of ventilation tube using operating microscope		78.60	
99394	- myringotomy under general anaesthetic – with/without operating microscope, unilateral		42.15	4
99396	- with insertion of drainage tube using operating microscope, unilateral		78.60	4
99398	Aspiration of serous otitis		11.45	4
Excision				
Mastoidectomy				
- simple				
99410	- child	37.03	328.50	6
99412	- adult or adolescent	37.03	328.50	6
99414	- radical or modified radical	37.03	627.10	7
99416	- revision mastoidectomy with revision of middle ear and regrafting	37.03	526.45	7
99420	- with meatoplasty and/or canalplasty		103.86	add
99422	- with ossiculoplasty		83.28	add
Repair				
99430	Myringoplasty	37.03	198.90	5
99432	Tympanoplasty including necessary mastoid or middle ear surgery	55.54	651.23	7
99440	Ossiculoplasty	37.03	415.49	7
99442	Facial nerve decompression	55.54	611.35	9
99444	Facial nerve graft	55.54	939.90	9
99446	Closure of mastoid fistula	37.03	239.95	4
99448	Exploratory tympanotomy		288.50	4
99450	Section tympanic plexus		352.20	6
99452	Tympanotomy with round or oval window fistula repair (IOP)		375.95	6

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES
OPERATIONS ON THE EAR

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
INNER EAR				
Incision				
99470	Labyrinthotomy or labyrinthectomy Surgical including Tack or Fick procedures or ultrasound	55.54	521.95	7
Repair				
99482	Fenestration of semicircular canals		348.80	6
99484	Stapes mobilization - unilateral		233.26	6
99486	Stapedectomy with prosthesis		644.54	6
99488	Posterior/Superior semicircular canal occlusion	55.54	612.70	8
99490	Endolymphatic shunt or sac decompression	37.03	629.60	9
99492	Temporal bone resection	37.03	1,379.10	9
Permanent Cochlear Prosthesis Insertion				
99500	Extra-cochlear (round window, middle ear)	64.80	509.00	9
99502	Intra-cochlear	64.80	719.71	9
99504	Bone conduction hearing aid insertion - implantable, including necessary mastoidectomy	37.03	345.15	6
ACOUSTIC NERVE				
99520	Translabyrinthine resection of acoustic neuroma (includes surgical approach and closure, any method)	101.83	2,673.21	15

ANAESTHESIA BASIC FEE CODE RATES

Anaesthesia basic fees must be claimed as dollar amounts and not as unit values

Listed Unit Value	Rate
1	\$16.95
2	\$33.90
3	\$50.85
4	\$67.80
5	\$84.75
6	\$101.70
7	\$118.65
8	\$135.60
9	\$152.55
10	\$169.50
11	\$186.45
12	\$203.40
13	\$220.35
14	\$237.30
15	\$254.25
16	\$271.20
17	\$288.15
18	\$305.10
19	\$322.05
20	\$339.00
21	\$355.95
22	\$372.90
23	\$389.85
24	\$406.80
25	\$423.75
26	\$440.70
27	\$457.65
28	\$474.60
29	\$491.55
30	\$508.50

Table II

October 1, 2019

ANAESTHETIC TIME UNITS - SURGICAL PROCEDURES

TIME		Units	Rate
From	To		
1 minute	15 minutes	1	\$14.53
16 minutes	30 minutes	2	\$29.06
31 minutes	45 minutes	3	\$43.59
46 minutes	60 minutes	4	\$58.12
1 hour 1 minute	1 hour 15 minutes	5	\$87.18
1 hour 16 minutes	1 hour 30 minutes	6	\$116.24
1 hour 31 minutes	1 hour 45 minutes	7	\$145.30
1 hour 46 minutes	2 hours	8	\$174.36
2 hours 1 minute	2 hours 15 minutes	9	\$217.95
2 hours 16 minutes	2 hours 30 minutes	10	\$261.54
2 hours 31 minutes	2 hours 45 minutes	11	\$305.13
2 hours 46 minutes	3 hours	12	\$348.72
3 hours 1 minute	3 hours 15 minutes	13	\$392.31
3 hours 16 minutes	3 hours 30 minutes	14	\$435.90
3 hours 31 minutes	3 hours 45 minutes	15	\$479.49
3 hours 46 minutes	4 hours	16	\$523.08
4 hours 1 minute	4 hours 15 minutes	17	\$566.67
4 hours 16 minutes	4 hours 30 minutes	18	\$610.26
4 hours 31 minutes	4 hours 45 minutes	19	\$653.85
4 hours 46 minutes	5 hours	20	\$697.44
5 hours 1 minute	5 hours 15 minutes	21	\$741.03
5 hours 16 minutes	5 hours 30 minutes	22	\$784.62
5 hours 31 minutes	5 hours 45 minutes	23	\$828.21
5 hours 46 minutes	6 hours	24	\$871.80
6 hours 1 minute	6 hours 15 minutes	25	\$915.39
6 hours 16 minutes	6 hours 30 minutes	26	\$958.98
6 hours 31 minutes	6 hours 45 minutes	27	\$1,002.57
6 hours 46 minutes	7 hours	28	\$1,046.16
7 hours 1 minute	7 hours 15 minutes	29	\$1,089.75
7 hours 16 minutes	7 hours 30 minutes	30	\$1,133.34

**EPIDURAL ANAESTHESIA FOR PAIN CONTROL
(Fee Codes 54134 and 80044)**

TIME		Units	Rate
From	To		
1 minute	15 minutes	1	\$16.95
16 minutes	30 minutes	2	\$33.90
31 minutes	45 minutes	3	\$50.85
46 minutes	60 minutes	4	\$67.80
61 minutes	1 hour 15 minutes	5	\$84.75
1 hour 16 minutes	1 hour 30 minutes	6	\$101.70
1 hour 31 minutes	1 hour 45 minutes	7	\$118.65
1 hour 46 minutes	2 hours	8	\$135.60
2 hours 1 minute	2 hours 15 minutes	9	\$152.55
2 hours 16 minutes	2 hours 30 minutes	10	\$169.50
2 hours 31 minutes	2 hours 45 minutes	11	\$186.45
2 hours 46 minutes	3 hours	12	\$203.40
Maximum of 12 units payable per day			

NOTES:

- A. For the day of admission to hospital, or of transfer from another specialty, claim for the admission exam – consult, assessment, reassessment as appropriate. Claim for day 2 as the first SHV date. Continue SHV billing as per the attached chart.
- B. From the day of transfer within the same specialty, claim for SHV's only, claiming the type as a continuation from the first physician.
- C. Separate claim items are required for each type SHV. That is, two types may not be combined and billed as one item. SHV's should be billed at least at the conclusion of type 2's and at the conclusion of type 3's, and, monthly thereafter.

SHV - SUBSEQUENT HOSPITAL VISIT - Type 2					
-					
Type SHV	Units	Rate	Type SHV	Units	Rate
2	1	\$31.00	2	19	\$589.00
2	2	\$62.00	2	20	\$620.00
2	3	\$93.00	2	21	\$651.00
2	4	\$124.00	2	22	\$682.00
2	5	\$155.00	2	23	\$713.00
2	6	\$186.00	2	24	\$744.00
2	7	\$217.00	2	25	\$775.00
2	8	\$248.00	2	26	\$806.00
2	9	\$279.00	2	27	\$837.00
2	10	\$310.00	2	28	\$868.00
2	11	\$341.00	2	29	\$899.00
2	12	\$372.00	2	30	\$930.00
2	13	\$403.00	2	31	\$961.00
2	14	\$434.00	2	32	\$992.00
2	15	\$465.00	2	33	\$1,023.00
2	16	\$496.00	2	34	\$1,054.00
2	17	\$527.00	2	35	\$1,085.00
2	18	\$558.00			

Table V

October 1, 2019

NOTES:

- A. From the day of transfer within the same specialty, claim for SHV's only, claiming the type as a continuation from the first physician.
- B. Type 4 SHV's do not have a limitation. The rate listed is the rate per day after type 3 SHV's have concluded.
- C. Separate claim items are required for each type SHV. That is, two types may not be combined and billed as one item. SHV's should be billed at least at the conclusion of type 2's and at the conclusion of type 3's, and, monthly thereafter.

SHV- SUBSEQUENT HOSPITAL VISIT - Type 3 and 4								
Type SHV	Units	Family Medicine	Neurology	Obstetrics/ Gynecology	Pediatrics	Physical Medicine	Psychiatry	All Others
3	1	\$19.49	\$21.61	\$20.33	\$19.63	\$20.35	\$22.06	\$21.10
3	2	\$38.98	\$43.22	\$40.66	\$39.26	\$40.70	\$44.12	\$42.20
3	3	\$58.47	\$64.83	\$60.99	\$58.89	\$61.05	\$66.18	\$63.30
3	4	\$77.96	\$86.44	\$81.32	\$78.52	\$81.40	\$88.24	\$84.40
3	5	\$97.45	\$108.05	\$101.65	\$98.15	\$101.75	\$110.30	\$105.50
3	6	\$116.94	\$129.66	\$121.98	\$117.78	\$122.10	\$132.36	\$126.60
3	7	\$136.43	\$151.27	\$142.31	\$137.41	\$142.45	\$154.42	\$147.70
3	8	\$155.92	\$172.88	\$162.64	\$157.04	\$162.80	\$176.48	\$168.80
3	9	\$175.41	\$194.49	\$182.97	\$176.67	\$183.15	\$198.54	\$189.90
3	10	\$194.90	\$216.10	\$203.30	\$196.30	\$203.50	\$220.60	\$211.00
3	11	\$214.39	\$237.71	\$223.63	\$215.93	\$223.85	\$242.66	\$232.10
3	12	\$233.88	\$259.32	\$243.96	\$235.56	\$244.20	\$264.72	\$253.20
3	13	\$253.37	\$280.93	\$264.29	\$255.19	\$264.55	\$286.78	\$274.30
3	14	\$272.86	\$302.54	\$284.62	\$274.82	\$284.90	\$308.84	\$295.40
3	15	\$292.35	\$324.15	\$304.95	\$294.45	\$305.25	\$330.90	\$316.50
3	16	\$311.84	\$345.76	\$325.28	\$314.08	\$325.60	\$352.96	\$337.60
3	17	\$331.33	\$367.37	\$345.61	\$333.71	\$345.95	\$375.02	\$358.70
3	18	\$350.82	\$388.98	\$365.94	\$353.34	\$366.30	\$397.08	\$379.80
3	19	\$370.31	\$410.59	\$386.27	\$372.97	\$386.65	\$419.14	\$400.90
3	20	\$389.80	\$432.20	\$406.60	\$392.60	\$407.00	\$441.20	\$422.00
3	21	\$409.29	\$453.81	\$426.93	\$412.23	\$427.35	\$463.26	\$443.10
3	22	\$428.78	\$475.42	\$447.26	\$431.86	\$447.70	\$485.32	\$464.20
3	23	\$448.27	\$497.03	\$467.59	\$451.49	\$468.05	\$507.38	\$485.30
3	24	\$467.76	\$518.64	\$487.92	\$471.12	\$488.40	\$529.44	\$506.40
3	25	\$487.25	\$540.25	\$508.25	\$490.75	\$508.75	\$551.50	\$527.50

SHV - SUBSEQUENT HOSPITAL VISIT

Type SHV	Units	Family Medicine	Neurology	Obstetrics/ Gynecology	Pediatrics	Physical Medicine	Psychiatry	All Others
3	26	\$506.74	\$561.86	\$528.58	\$510.38	\$529.10	\$573.56	\$548.60
3	27	\$526.23	\$583.47	\$548.91	\$530.01	\$549.45	\$595.62	\$569.70
3	28	\$545.72	\$605.08	\$569.24	\$549.64	\$569.80	\$617.68	\$590.80
3	29	\$565.21	\$626.69	\$589.57	\$569.27	\$590.15	\$639.74	\$611.90
3	30	\$584.70	\$648.30	\$609.90	\$588.90	\$610.50	\$661.80	\$633.00
3	31	\$604.19	\$669.91	\$630.23	\$608.53	\$630.85	\$683.86	\$654.10
3	32	\$623.68	\$691.52	\$650.56	\$628.16	\$651.20	\$705.92	\$675.20
3	33	\$643.17	\$713.13	\$670.89	\$647.79	\$671.55	\$727.98	\$696.30
3	34	\$662.66	\$734.74	\$691.22	\$667.42	\$691.90	\$750.04	\$717.40
3	35	\$682.15	\$756.35	\$711.55	\$687.05	\$712.25	\$772.10	\$738.50
3	36	\$701.64	\$777.96	\$731.88	\$706.68	\$732.60	\$794.16	\$759.60
3	37	\$721.13	\$799.57	\$752.21	\$726.31	\$752.95	\$816.22	\$780.70
3	38	\$740.62	\$821.18	\$772.54	\$745.94	\$773.30	\$838.28	\$801.80
3	39	\$760.11	\$842.79	\$792.87	\$765.57	\$793.65	\$860.34	\$822.90
3	40	\$779.60	\$864.40	\$813.20	\$785.20	\$814.00	\$882.40	\$844.00
3	41	\$799.09	\$886.01	\$833.53	\$804.83	\$834.35	\$904.46	\$865.10
3	42	\$818.58	\$907.62	\$853.86	\$824.46	\$854.70	\$926.52	\$886.20
3	43	\$838.07	\$929.23	\$874.19	\$844.09	\$875.05	\$948.58	\$907.30
3	44	\$857.56	\$950.84	\$894.52	\$863.72	\$895.40	\$970.64	\$928.40
3	45	\$877.05	\$972.45	\$914.85	\$883.35	\$915.75	\$992.70	\$949.50
3	46	\$896.54	\$994.06	\$935.18	\$902.98	\$936.10	\$1,014.76	\$970.60
3	47	\$916.03	\$1,015.67	\$955.51	\$922.61	\$956.45	\$1,036.82	\$991.70
3	48	\$935.52	\$1,037.28	\$975.84	\$942.24	\$976.80	\$1,058.88	\$1,012.80
3	49	\$955.01	\$1,058.89	\$996.17	\$961.87	\$997.15	\$1,080.94	\$1,033.90
3	50	\$974.50	\$1,080.50	\$1,016.50	\$981.50	\$1,017.50	\$1,103.00	\$1,055.00
3	51	\$993.99	\$1,102.11	\$1,036.83	\$1,001.13	\$1,037.85	\$1,125.06	\$1,076.10
3	52	\$1,013.48	\$1,123.72	\$1,057.16	\$1,020.76	\$1,058.20	\$1,147.12	\$1,097.20
3	53	\$1,032.97	\$1,145.33	\$1,077.49	\$1,040.39	\$1,078.55	\$1,169.18	\$1,118.30
3	54	\$1,052.46	\$1,166.94	\$1,097.82	\$1,060.02	\$1,098.90	\$1,191.24	\$1,139.40
3	55	\$1,071.95	\$1,188.55	\$1,118.15	\$1,079.65	\$1,119.25	\$1,213.30	\$1,160.50
3	56	\$1,091.44	\$1,210.16	\$1,138.48	\$1,099.28	\$1,139.60	\$1,235.36	\$1,181.60

SHV - SUBSEQUENT HOSPITAL VISIT

Type SHV	Units	Family Medicine	Neurology	Obstetrics/ Gynecology	Pediatrics	Physical Medicine	Psychiatry	All Others
4	1	\$6.80	\$20.81	\$19.58	\$18.90	\$19.60	\$21.24	\$20.32
4	2	\$13.60	\$41.62	\$39.16	\$37.80	\$39.20	\$42.48	\$40.64
4	3	\$20.40	\$62.43	\$58.74	\$56.70	\$58.80	\$63.72	\$60.96
4	4	\$27.20	\$83.24	\$78.32	\$75.60	\$78.40	\$84.96	\$81.28
4	5	\$34.00	\$104.05	\$97.90	\$94.50	\$98.00	\$106.20	\$101.60

Table VI

October 1, 2025

**UNITS TABLE FOR SURGICAL ASSISTANTS BILLING
ACCORDING TO STANDARD TIME METHOD**

Units	Rate
1	\$38.57
2	\$77.14
3	\$115.71
4	\$154.28
5	\$192.85
6	\$231.42
7	\$269.99
8	\$308.56
9	\$347.13
10	\$385.70
11	\$424.27
12	\$462.84
13	\$501.41

Units	Rate
14	\$539.98
15	\$578.55
16	\$617.12
17	\$655.69
18	\$694.26
19	\$732.83
20	\$771.40
21	\$809.97
22	\$848.54
23	\$887.11
24	\$925.68
25	\$964.25

**UNITS TABLE FOR SURGICAL ASSISTANTS BILLING
ACCORDING TO DEDICATED TIME METHOD**

Units	Rate
1	\$35.36
2	\$70.72
3	\$106.08
4	\$141.44
5	\$176.80
6	\$212.16
7	\$247.52
8	\$282.88
9	\$318.24
10	\$353.60
11	\$388.96
12	\$424.32
13	\$459.68

Units	Rate
14	\$495.04
15	\$530.40
16	\$565.76
17	\$601.12
18	\$636.48
19	\$671.84
20	\$707.20
21	\$742.56
22	\$777.92
23	\$813.28
24	\$848.64
25	\$884.00