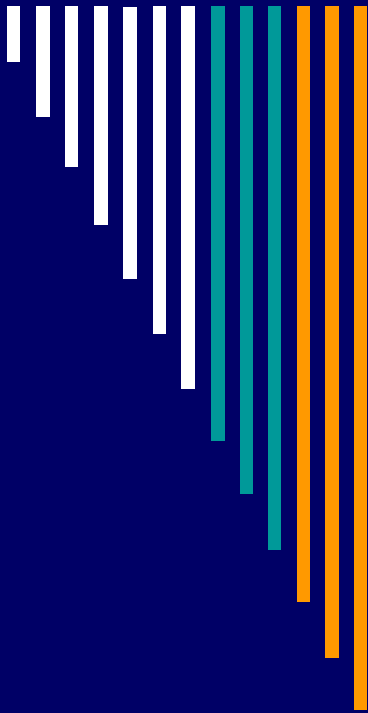


**mcp**

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# Medical Payment Schedule

Medical Care Plan  
Department of Health & Community Services

Effective April 1, 2009

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## GENERAL PREAMBLE

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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 the Payment Schedule are subject to existing policies of Capping, as well as any other 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**

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**2. INTRODUCTION**

The Payment Schedule is divided into a number of sections:

- General Preamble
- Appendices
- Visit Premiums
- Consultations and Visits
- Critical Care
- Diagnostic and Therapeutic Procedures
- In-Hospital Diagnostic Procedures
- 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
- DOHCS 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.

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**GENERAL PREAMBLE**

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**2.4 Consultations and Visits**

- (a) Visit codes are listed for each of the specialties, beginning with General Practice 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 General Practice 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
  - DOHCS 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.

**2.5 Critical Care**

This section of the Schedule lists the fees for CPR and the per diem fees 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 Procedures**

Diagnostic and Therapeutic Procedures is a section of the Payment Schedule which was designed for the billing of procedures performed in various places, e.g. hospital or office, as listed.

**2.7 In-Hospital Diagnostic Procedures**

Fees for reporting specific diagnostic procedures performed in hospital are listed in this section of the Schedule.

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**GENERAL PREAMBLE**

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**2.8 Radiology**

This section of the Schedule lists fees and describes conditions for the billing of Diagnostic Imaging 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 anaesthetic 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 General Practitioners, Surgical Assistants, Surgeons, and for Anaesthesiologists may be listed for each procedure. Where no fee is listed in the General Practice Column, 90% of the amount listed in the Specialist column applies to General Practice. 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 and III - Anaesthetic Time Units - Surgical Procedures
- IV - Epidural Anaesthesia for Pain Control
- V - SHV - Subsequent Hospital Visits
- VI - Units Table for Surgical Assistants - Billing According to Standard Method
- VII - Units Table for GP Surgical Assistants - Billing According to Dedicated Time Method

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**GENERAL PREAMBLE**


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**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. The clinical need of the provision and claim of an insured service may be evaluated by the Medical Consultants' Committee of MCP;

The policies on pre-existing conditions necessary to define "medical necessity" exist for the following services to qualify as MCP insured services: reduction mammoplasty, augmentation mammoplasty, blepharoplasty, and the laser treatment of vascular lesions. Copies of these policies are available upon request from the office of the Director of Physician Services or the Assessing Department. Regulations with respect to insurability of scar revision are listed in Appendix F, and/or;

- (c) recommended by the Department of Health and Community Services (DOHCS), e.g. Immunization Programs, as per Public Health recommendations (see Appendix D).

**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 Physician 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.

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## GENERAL PREAMBLE

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

An automatic annual recall program of women for PAP smear examinations will not be viewed by MCP as constituting solicitation.

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

Payment for medical and professional services which are research-related or experimental are not the financial responsibility of MCP. Only those 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 an insured service.

### 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 DOHCS,
- (h) conferring with and/or providing advice, direction or information to physicians and other professionals associated with the health and development of the patient,
- (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**

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**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. However, in exceptional circumstances, the Medical Consultants' Committee may recommend that MCP audit up to five 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**

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**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 listed 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 listed in the Payment Schedule, and
- (e) a copy of the operative report along with the actual operating time for complex surgical procedures.

**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.

**GENERAL PREAMBLE**

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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.

**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. 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

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

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 General Practitioners to residents of DOHCS designated long term care facilities (see Appendix C) must be claimed using dedicated nursing home visit codes for General Practice. 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 a physician to a registered hospital in-patient. For claiming purposes, MCP recognizes facilities designated by the DOHCS 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

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**GENERAL PREAMBLE**


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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.

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

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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 requests 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:

- (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 requests 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 Nurse Practitioner Primary Health Care 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 that 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 General Practice rate. If there is no equivalent General Practice code, then the service should be billed at the

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General Practice office Partial Assessment rate. 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.
- (c) In a general/family practice 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.

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

“**Consultation**” refers to the situation where licensed physicians or Nurse Practitioners 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.

**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 of 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.

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This rule applies regardless of diagnosis and referral source.

- 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 SHVs.
- 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.
- 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. Each consultation claimed must be the result of a new referral.
- 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 **Major Medical Consultation:** This service may only be claimed by specialists in 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,



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- (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.

6.4.2 **Trauma Consultation:** This service may be claimed by specialists in General Surgery, Neurosurgery and Orthopaedics 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.

6.4.3 **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.

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

6.4.5 **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.

6.4.6 **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 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.

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,

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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 the 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 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. This service may be claimed as often as it is medically necessary.
- 6.9 **Radiology Consultation:** A diagnostic radiology consultation applies when radiographs made elsewhere are referred to a Radiologist for his/her written opinion. It is not payable for the reading of radiographs sent for reporting. As well, a consultation does not apply when the radiographs referred to above are used for comparison purposes with radiographs 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.

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**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.

**7.1 Add on Fee for Scheduled After Hours General Practice Clinics**

- (a) Fee code 139 can be billed by General Practitioners 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 General Practice fee codes 101, 111, 112, 114, 118, 121, 122, 123, 124, 126, 131, 132, and 136. It is not payable with any other code;
- (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 GP 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 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.

**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:

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- (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 Concurrent Care**

7.6.1 This refers to the clinical situation where care by more than one physician is required for a hospital in-patient, exclusive of claims for team fees in special care units. Separate claims must be submitted, with Concurrent Care being claimed IC, except when the patient is in an intensive care setting. Concurrent Care must be verifiable as having been requested by the attending physician.

7.6.2 Concurrent Care for a patient in an ICU, NICU or CCU must be billed using fee code 51790 instead of the regular SHV codes. 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.

7.6.3 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 an IC

**7.7 Detention**

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

7.7.2 Detention is not payable for:

- (a) usual preoperative or postoperative care by the operating surgeon,

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- (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, or for patient arrival.

7.7.3 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.

7.7.4 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.
- (d) For General Practitioners' claims, detention time units are calculated beginning at the time the patient encounter commences.

7.8 **Directive Care**

Consultants providing "directive care" may claim a major visit code reflective of the service provided, as well as one visit every two days for the first week and one visit every four days for Concurrent Care services while the patient's condition remains serious. Follow up visits must be claimed IC

7.9 **Escort of a Critically Ill Patient**

7.9.1 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.

7.9.2 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

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(b) the critical nature of the illness requiring physician presence.

7.9.3 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.

7.10 **General Assessments**

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

7.10.2 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).

**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.

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

7.10.4 A General Assessment is payable for annual and admission General Assessments rendered to residents of DOHCS 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,
- (b) 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
- (d) 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.

7.10.5 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.

7.10.6 The first visit for the purpose of initiating the use of the birth control pill is deemed to warrant a General Assessment being claimed.

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**7.11 General Reassessment**

A General Reassessment shall consist of the same services 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.

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

**7.13 Home Visits by General Practitioners**

7.13.1 An **Elective Home Visit** rendered by a General Practitioner 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.

7.13.2 A **Non-Elective Home Visit** rendered by a General Practitioner 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.

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

**7.14 In-Patient Surcharges for General Practitioners**

7.14.1 Fee code 355 may be claimed by General Practitioners 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.

7.14.2 Fee code 359 may be claimed by General Practitioners 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.

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**7.15 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.

**7.16 Newborn Baby Care**

7.16.1 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.

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

**7.17 Partial Assessment**

7.17.1 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.

7.17.2 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.

7.17.3 A visit for a requested Pap Smear 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.

**7.18 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.

**7.19 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.

**7.20 Partial Assessment of a Patient Who Received a WHSCC Service During the Same Office Visit**



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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.

**7.21      Physiatric 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.

**7.22      Pre-Anaesthetic Clinic Assessment**

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

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

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

**7.23      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.

**7.24      Psychiatric Care**

7.24.1      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.

7.24.2      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).

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

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**7.24.4 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.

<b>Individual</b>
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

**7.25 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.

**7.26 Psychotherapy**

7.26.1 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.

7.26.2 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.

7.26.3 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 counseling may be claimed as psychotherapy.

7.26.4 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).

7.26.5 Psychotherapy is not payable on the same day as ECT.

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7.26.6 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

7.27 **Routine Post-Operative Care by General Practitioners**

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

7.28 **Specific Assessment**

7.28.1 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.

7.28.2 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.

7.29 **Specific Reassessment**

7.29.1 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.

7.29.2 Specific Reassessments apply in the management and assessment of the progress of serious chronic diseases and should not be claimed for treating minor conditions, nor solely for following the progress of treatment.

7.29.3 The second and subsequent Specific Assessments on a patient within each 90 days should be claimed as Specific Reassessments.

7.30 **Subsequent Hospital Visits (SHVs)**

SHVs may be claimed for continuing care of hospital in-patients by attending physicians, and for requested follow-up visits by consulting 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. Premiums for any additional “Special Visits” as defined in this Preamble may be applicable.

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**7.31 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.

**7.32 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.

**7.33 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 measurements, 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."

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**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 patients in Neonatal Intensive Care Units designated by the DOHCS. 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) insertion 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 of 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.
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**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 DOHCS. 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 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,
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- (d) all services listed for renal dialysis,
- (e) electrical cardioversion,
- (f) endotracheal intubation, when 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 supercedes 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 the ICU/CCU within 48 hours of discharge, second day benefits apply. After 48 hours, first day benefits apply.

8.2.9 Consultation 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 render 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.

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**9. DIAGNOSTIC AND THERAPEUTIC PROCEDURES**

- 9.1 This section of the Schedule identifies the amounts payable for professional services that may be performed in either an office, home, or hospital environment. 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 DOHCS are as follows:
- (a) visit for assessment plus single immunization - claim visit fee only,
  - (b) visit for assessment plus two immunizations - claim visit fee plus one unit of fee code 54656,
  - (c) visit for immunization against influenza and pneumococcal disease - claim one unit of 54650 and one unit of 54656,
  - (d) visit for immunization against influenza only - claim one unit of fee code 54650, and
  - (e) visit for immunization against pneumococcal disease only - claim one unit each of fee codes 54000 and 54658.
- 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 DOHCS 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.
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- (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 DOHCS 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**

**Fee Code 54333 is billable under the following conditions:**

**9.6.1 The advanced mapping system is used in hospital for mapping the following arrhythmias:**

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

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

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**10. IN-HOSPITAL DIAGNOSTIC PROCEDURES**

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 fees 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 those patients.

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**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.
- 11.6 No additional fees are to be charged for:
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- (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.
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- 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 Saturday),
  - (b) Special visits during evenings - (6:00 p.m. to midnight, 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.

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**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 Saturday), or
  - (b) Special visits during evenings - (6:00 p.m. to midnight, 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.
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**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 for up to 18 hours.
- 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 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 first 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.

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**14. SURGICAL PROCEDURES**

14.1 Surgical fee codes are “bundled” and not divisible, with the exception of “team” fee codes (each physician is paid 50% of the listed fee). Unless otherwise stated, the fee listed for a surgical procedure includes the following:

- (a) the procedure, including the surgical approach and closure,
- (b) all examinations other than consultations rendered within two days prior to the procedure,
- (c) pre-operative care for two days prior to the procedure,
- (d) 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 from 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

- (e) 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 kilometres 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 codes, 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) pre and post-operative visits not related to procedure:

Visits made within the two day pre-operative period or 42 days 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.



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Remarks Code 20 must be used by General Practitioners claiming these services.

- (f) 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.
- (g) routine post-operative care by General Practitioners:  
General Practitioners 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 the 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 a listed combined tariff. In those cases, the additional surgeon may claim assistant’s fees 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.

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- 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 procedural 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 procedural fee.
- 14.12 Where hypothermia is used, a charge in addition to the procedural fee should be made by the surgeon, unless otherwise specified. See fee code 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.

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**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 "a 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.
- 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:
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- (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 re-assessed.
- (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.

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**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 operating 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.

16.1.8 Payments to General Practitioners for surgical assistant's services billed using the Standard method will be adjusted by MCP to reflect increased funding made available during the micro-allocation process.

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**16.2 Dedicated Time Method of Billing for General Practitioners**

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

16.2.2 Dedicated time is defined as time spent by General Practitioners 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 Tables 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 General Practitioner 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 General Practitioner 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 General Practitioner 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 who 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 Assessing Manager. 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 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.

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**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 materials 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) Where the basic fee amount is equivalent to 1-3 time units or 6 or more time units, time units in excess of two hours but less than four hours are payable at double the listed time unit rate. Units tables for convenience of billing are located in the Tables Section of this Payment Schedule.
- (b) Where the basic fee amount is equivalent to 4-5 time units, time units in excess of one hour but less than four hours are payable at double the listed time unit rate. Units tables for convenience of billing are located in the Tables Section of this Payment Schedule.
- (c) Time units in excess of four 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 services in capacity 3, any services 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
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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.

- (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 being 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 regular intubation is impossible and is not payable as a routine replacement. Use fee code 90016.
- (c) **One lung anaesthesia** - This is payable when a double-lumen endotracheal tube is placed which permits selective ventilation of either lung as required by the thoracic procedure being performed. Use fee code 90018.
- (d) Children under the age of 1. Use fee code 90024.
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- (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.
  - (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.
- 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
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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.
- 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.

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**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 Sections 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 benefit 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 an SHV applies.

**18.2.1 Home Visit Premiums**

This term applies to all physicians and home visits except home visits made by General Practitioners. Home visits and "extra patient seen" during a home visit by

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General Practitioners 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.

**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 that 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 Sundays and Statutory Holidays.
  - (b) Special Surgeons who perform 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 7:00 a.m. and 6:00 p.m. on Saturdays. Anaesthesiologists and Surgical Assistants who participate in such procedures are eligible for payment of a premium.
  - (c) 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.
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**18.3.1 Surgeons' Procedural Premiums:**

- (a) For procedures that qualify and commence between 6:00 p.m. and midnight, or on Sundays or Statutory Holidays:  
Claim 30% of each procedure billed, using premium code 01.
- (b) For procedures performed by Specialist Surgeons that qualify and commence between 7:00 a.m. and 6:00 p.m. on Saturday:  
Claim 30% of each procedure billed, using premium code 01.
- (c) 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 procedures that qualify and commence between 6:00 p.m. and midnight, or on Sundays or Statutory Holidays:  
Claim 46% of the basic and time unit fees billed, using premium code 02.
- (b) For procedures performed by Specialist Surgeons that qualify and commence between 7:00 a.m. and 6:00 p.m. on Saturday:  
Claim 46% of the basic and time unit fees billed, using premium code 02.
- (c) 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.

**18.3.3 Surgical Assistants' Procedural Premiums:**

- (a) For procedures that qualify and commence between 6:00 p.m. and midnight, or on Sundays or Statutory Holidays:  
Claim 30% of each assistant's fee payable, using premium code 01.
- (b) For procedures performed by Specialist Surgeons that qualify and commence between 7:00 a.m. and 6:00 p.m. on Saturday:  
Claim 30% of each assistant's fee payable, using premium code 01.
- (c) 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 All operative deliveries and Caesarean Sections performed after hours qualify for premiums. For the delivering physician, code 81008 applies from 12:01 a.m. to 7:00 a.m., while procedure premium code 01 applies from 6:00 p.m. to midnight and for Sundays and Statutory Holidays. Procedural premium codes 01 and 03 apply for assistants and 02 and 03 apply for Anaesthesiologists.

18.4.2 Normal deliveries (fee code 80004) performed after hours by specialists or General Practitioners qualify for a premium when performed between 12:01 a.m. and 7:00 a.m. For these deliveries, fee code 80008 applies for the delivering physician, and procedural premium code 03 applies for the Anaesthesiologist.

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- 18.4.3 Normal deliveries (fee code 80004) performed by General Practitioners, qualify for a premium when performed between 6:00 p.m. and midnight. For these deliveries, fee code 80007 applies for the delivering General Practitioner.
- 18.4.4 Normal deliveries (fee code 80004) performed at times other than those specified above do not qualify for a premium.

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**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.
- 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 arrangements require individual pre-approval from MCP and must be requested in writing by the Administrator of the institution requiring the sessional service.

**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.
- 19.2.5 No fee-for-service billings should occur during the time dedicated to a 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.
- 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.

General Practice	<b>\$321.61</b> per half day
Specialist	<b>\$409.85</b> 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 of **\$132.64**. 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-

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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 DOHCS.

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 be officially 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 anytime, 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.



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**20. CATEGORY 'B' EMERGENCY DEPARTMENT COVERAGE BY FEE-FOR-SERVICE GENERAL PRACTITIONERS**

20.1 Fee-for-service General Practitioners who are scheduled to immediately respond to the emergency needs of 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 DHCS 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 \$41.18 must be billed for daytime coverage 8:00 a.m. to 6:00 p.m. Monday to Friday. During that time fee-for-service General Practitioners 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 General Practitioners may bill an all inclusive hourly rate of \$73.00 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 \$73.00 is billed no fee-for-service claims are payable. Alternatively, they may bill the hourly rate of \$41.18 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.

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**21. LONG TERM CARE FACILITY COVERAGE BY GENERAL PRACTITIONERS**

- 21.1 Fee-for-service General Practitioners who provide clinical services and coverage to DOHCS designated long term care facilities that have long term care beds are eligible for payment 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 fee codes for General Practice. The home's facility number must be entered on claims for these services.

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**22. PHYSICIAN REGISTRATION**

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

**23. LOCUM COVERAGE**

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

**24. CMPA REBATE**

- 24.1 Fee-for-service physicians will be reimbursed for CMPA dues at the rate of 90% of the difference between the basic GP rate and the actual premium, subject to a maximum contribution rate for any physician of \$5,000 per annum.
- 24.2 To qualify, a physician must be in active practice at the end of the calendar year, or have retired from clinical services during the year.
- 24.3 To claim the rebate, the original acknowledgement of a physician's premium classification for each month of the year must be submitted to MCP.
- 24.4 To be eligible for the rebate, the required documentation must be received by MCP prior to the deadline as published in the applicable MCP Newsletter at the beginning of each calendar year. It is the responsibility of an eligible physician to claim for reimbursement.
- 24.5 For additional information regarding CMPA rebate eligibility and payment, contact the Manager of Accounting Services at 729-2304.

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

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

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

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

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

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Facility Number	Facility Name	Rate
800	Glenbrook Lodge, St. John's	\$152.06
802	St. Patrick's Mercy Home, St. John's	\$225.98
804	St. Luke's Nursing Home, St. John's	\$134.11
806	Agnes Pratt Nursing Home, St. John's	\$143.62
808	Masonic Park Senior Citizens Home, St. John's	\$43.30
810	Hoyles/Escasoni Complex, St. John's	\$420.29
812	Harbour Lodge Nursing Home, Carbonear	\$134.11
814	Interfaith Citizens Home, Carbonear	\$58.08
816	Pentecostal Senior Citizens Home, Clarkes Beach	\$87.65
818	Blue Crest Interfaith Home, Grand Bank	\$79.20
<b>819</b>	<b>Dr. Albert O'Mahony Memorial Manor</b>	<b>\$46.46</b>
820	Lakeside Homes, Gander	\$114.05
822	Carmelite House, Grand Falls-Windsor	\$63.36
825	Corner Brook Long Term Care Home	\$249.22
828	Bay St. George Senior Citizens Home, Stephenville Crossing	\$133.06
832	John M. Gray Centre, St. Anthony	\$52.80
834	Labrador South Health Centre, Forteau	\$8.45
836	Long Term Care Home, Happy Valley-Goose Bay	\$52.80

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## IMMUNIZATION OF DESIGNATED TARGET POPULATIONS

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Immunization of target populations designated by the DOHCS 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 INFLUENZA

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

- adults and children with chronic cardiac or pulmonary disorders (including bronchopulmonary dysplasia, cystic fibrosis, and asthma) severe enough to require regular medical follow-up or hospital care,
- residents of any age in nursing homes and other chronic care facilities,
- beneficiaries over the age of 65,
- adults and children with chronic conditions such as diabetes and other metabolic diseases, cancer, immunodeficiency, immunosuppression, renal disease, anemia, and hemoglobinopathy,
- children and adolescents treated for long periods with acetylsalicylic acid,
- healthy children aged 6 to 23 months (i.e. under two years of age),
- people at high risk of influenza complications embarking on travel to destinations where influenza is likely to be circulating,
- any person working in a health care setting (institution or community),
- household contacts (including children) of people at high risk who either cannot be vaccinated or may respond inadequately to vaccination,
- essential services workers (police, ambulance, firefighters, municipal workers responsible for maintaining water, sewage and waste disposal services, power/hydro and telephone workers, or other persons in the community whose services may be considered essential),
- people who work directly in the poultry industry, or,
- any other person as directed or approved by the Medical Officer of Health for the region.

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**IMMUNIZATION OF DESIGNATED TARGET POPULATIONS**

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**IMMUNIZATION AGAINST PNEUMOCOCCAL DISEASE**

The target population designated by the DOHCS for immunization against pneumococcal disease is limited to the following categories of beneficiaries:

- All residents of long term care facilities,
- People aged 65 and over,
- Chronic cardiac disease,
- Chronic respiratory disease,
- Diabetes mellitus,
- Chronic renal disease,
- Chronic neurological disease with risk of aspiration, or cerebrospinal fluid leak,
- Documented immune disorder associated with recurrent infections,
- Hodgkin's disease, lymphoma, multiple myeloma and induced immunosuppression,
- Bronchial pulmonary dysplasia or other severe respiratory disease related to prematurity,
- Alcoholism,
- Cirrhosis of the liver,
- Asplenia or splenic dysfunction,
- Sickle-cell disease,
- Persons with cochlear implants, or
- Other populations who may be vulnerable.



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**NON-INSURED SERVICES LIST**

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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 Director of Physician 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 DOHCS. (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 MCP,
- experimental treatments and procedures,
- services associated with clinical trials,
- services associated with environmental clinics,
- laser surgery for vascular lesions not listed in existing DOHCS 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.

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**SCAR REVISION**

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## 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 functional impairment.

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.

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**HYPERBARIC OXYGEN THERAPY**

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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 Problem 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

PREMIUMS

Code G.P. Spec.

**Office (or visit to Physician's Residence - see applicable Preamble section)**

Special visit to the office premiums - (1<sup>st</sup> patient seen) - to be billed in addition to applicable office visit fee code

50	Monday to Saturday between 8:00 a.m. and 6:00 p.m. outside regular scheduled office hours.	20.18	14.25
52	Sundays or Statutory Holidays or 6:00 p.m. to midnight.....	25.18	28.50
53	Patient initiated non-elective (special) service rendered between midnight and 8:00 a.m.....	30.18	42.80

- NOTES:**
1. *Special visit premiums are not payable in addition to the following services:*
    - visit for well-baby care
    - detention
  2. *No premiums are payable for extra patients seen outside regular hours in the physician's office or residence.*

**Home (Not applicable to General Practice - see applicable Preamble section)**

Special visit to the home premiums - (1<sup>st</sup> patient seen) - to be billed in addition to applicable home visit fee code.

	Monday to Saturday between 8:00 a.m. and 6:00 p.m.		
60	- without sacrifice of office hours .....	N.A.	14.25
61	- with sacrifice of office hours .....	N.A.	28.50
62	Sundays or Statutory Holidays or 6:00 p.m. to midnight.....	N.A.	28.50
63	Patient initiated non-elective (special) service rendered between midnight and 8:00 a.m.....	N.A.	42.80

Extra patient seen premiums

	Monday to Saturday between 8:00 a.m. and 6:00 p.m.		
66	- without sacrifice of office hours .....	N.A.	8.15
67	- with sacrifice of office hours.....	N.A.	12.20
68	Sundays or Statutory Holidays or 6:00 p.m. to midnight.....	N.A.	12.20
69	Midnight to 8:00 a.m. ....	N.A.	18.70

**NOTE:** *Special visit premiums are not payable in addition to detention.*

**Hospital In-Patient (see applicable Preamble Section)**

Premiums on in-patient services - (1<sup>st</sup> patient seen) - to be billed in addition to applicable in-patient fee code or alone if visit is not payable

	Monday to Saturday between 8:00 a.m. and 6:00 p.m.		
	Physician in-hospital.....	N.A.	N.A.
70	- special visit, without sacrifice of office hours .....	16.07	16.07
71	- special visit with sacrifice of office hours .....	32.04	32.04
72	Sundays or Statutory Holidays or 6:00 p.m. to midnight.....	45.05	45.05
73	Non-elective (special) service rendered between midnight and 8:00 a.m.....	67.59	67.59

Extra patient seen premiums - (in-patient) (when the physician has been specifically requested to see the patient)

	Monday to Saturday between 8:00 a.m. and 6:00 p.m.		
76	- without sacrifice of office hours .....	9.14	9.14
77	- with sacrifice of office hours .....	13.73	13.73
78	Sundays or Statutory Holidays or 6:00 p.m. to midnight.....	21.96	21.96
79	Midnight to 8:00 a.m. ....	33.03	33.03

**NOTE:** *Special visit premiums are not payable in addition to detention.*

CONSULTATIONS AND VISITS

PREMIUMS

Code G.P. Spec.

**Hospital Out-Patient and Emergency - (see applicable Preamble section)**

Premiums for physicians doing dedicated on-site emergency department coverage at approved Category 'A' facilities - to be billed in addition to visit fee code

**NOTE:** *First patient seen during on-site coverage may be claimed as a special visit.*

First patient seen on shift

80	- Monday to Saturday, 8:00 a.m. to 6:00 p.m.....	23.00	14.25
82	- Sundays or Statutory Holidays, or 6:00 p.m. to midnight.....	28.00	28.50
83	- midnight to 8:00 a.m. ....	33.00	42.80
	Each additional patient seen on shift		
	- Monday to Saturday, 8:00 a.m. to midnight .....	N.A.	N.A.
88	- Sundays or Statutory Holidays, 8:00 a.m. to midnight .....	3.60	3.60
89	- midnight to 8:00 a.m. ....	5.90	5.90

Premiums on Emergency or OPD services - for physicians not doing dedicated on-site emergency department coverage at approved Category 'A' facilities - (1<sup>st</sup> patient seen) - to be billed in addition to applicable visit fee code.

Monday to Saturday between 8:00 a.m. and 6:00 p.m.

- physician already in-hospital - no charge

90	- special visit, without sacrifice of office hours .....	24.82	16.07
91	- special visit, with sacrifice of office hours .....	31.54	32.04
92	Sundays or Statutory Holidays or 6:00 p.m. to midnight .....	45.55	45.05
93	Non-elective (special) service rendered between midnight and 8:00 a.m. ....	57.79	67.59

Extra patient seen premiums - (Emergency or OPD)

Monday to Saturday between 8:00 a.m. and 6:00 p.m.

96	- without sacrifice of office hours.....	9.14	9.14
97	- with sacrifice of office hours.....	13.73	13.73
98	Sundays or Statutory Holidays or 6:00 p.m. to midnight .....	22.96	21.96
99	Midnight to 8:00 a.m. ....	33.03	33.03

- NOTES:**
1. *Special visit premiums are not applicable for scheduled OPD clinics.*
  2. *Special visit premiums are not payable in addition to detention.*

**CONSULTATIONS AND VISITS**

**GENERAL PRACTICE**

Code		Rate
<b>Office</b>		
101	Consultation.....	55.00
111	Pre-dental general assessment.....	51.50
112	General assessment.....	51.50
114	General reassessment.....	36.05
118	Routine post-operative care.....	27.07
121	Partial assessment.....	27.07
122	Visit for <u>w</u> ell-baby care.....	27.07
123	Partial assessment of a patient who is 65 to 74 years of age.....	30.90
124	Partial assessment of a patient who is 75 years of age or older.....	35.29
126	Partial assessment of a patient who received a WHSCC service during the same office visit.....	27.07
<b>Psychotherapy:</b>		
131	Individual, per ½ hour or major part thereof.....	41.20
132	Group (4 to 8 people) per member, per hour or major part thereof.....	15.45
136	Family therapy (2 or more family members), per ½ hour, per family.....	25.75
139	Add on fee for patients seen in scheduled after hours clinics, billed using fee code 101 through 136..... add	7.72
181	<u>D</u> etention per ¼ hour.....	30.90
<b>Home</b>		
210	Nursing home <u>g</u> eneral assessment (except DOHCS designated facilities).....	51.50
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 Saturday (first patient seen).....	51.50
248	"Non-elective" rendered between 8:00 a.m. and midnight on a Sunday or Statutory Holiday (first patient seen).....	77.25
249	"Non-elective" rendered between 6:00 p.m. and midnight (first patient seen).....	77.25
250	"Non-elective" rendered between midnight and 8:00 a.m. (first patient seen).....	128.75
251	Emergency visit with sacrifice of office hours - rendered as an immediate response to a call from the patient or the patient's attendant.....	77.25
252	Extra patient seen during any home visit.....	25.75
281	<u>D</u> etention per ¼ hour.....	30.90
<b>DOHCS Designated Long Term Care Facilities With Long Term Beds</b>		
285	Nursing home <u>g</u> eneral assessment.....	51.50
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 Saturday (first patient seen).....	51.50
288	"Non-elective" nursing home visit rendered between 8:00 a.m. and midnight on a Sunday or Statutory Holiday (first patient seen).....	77.25
289	"Non-elective" nursing home visit rendered between 6:00 p.m. and midnight (first patient seen).....	77.25
290	"Non-elective" nursing home visit rendered between midnight and 8:00 a.m. (first patient seen).....	128.75
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).....	77.25
292	Extra patient seen during any nursing home visit.....	25.75

**CONSULTATIONS AND VISITS**

**GENERAL PRACTICE**

Code		Rate
<b>Hospital In-Patient</b>		
301	Consultation .....	55.00
311	<u>P</u> re-dental general assessment.....	51.50
312	<u>G</u> eneral assessment .....	51.50
314	<u>G</u> eneral reassessment .....	36.05
<u>P</u> sychotherapy		
331	Individual, (per ½ hour or major part thereof) .....	41.20
355	<u>I</u> n-patient surcharge for first 7 days - per diem .....	10.30
<u>S</u> ubsequent visits:		
356	Up to 5 weeks - per diem (visit type 2) .....	22.66
357	6 <sup>th</sup> to 13 <sup>th</sup> week inclusive - per diem (visit type 3).....	19.49
358	After 13 <sup>th</sup> week - per diem (visit type 4).....	6.80
359	<u>I</u> n-patient surcharge, day of discharge .....	25.75
<u>C</u> oncurrent care. For billing purposes, use subsequent hospital visit codes.		
361	<u>N</u> ewborn baby care .....	25.75
<u>S</u> upportive Care		
371	In 1 <sup>st</sup> 7 days - not exceeding 1 visit every 2 days - per visit.....	20.60
372	After 1 <sup>st</sup> 7 days - not exceeding 1 visit every 4 days - per visit .....	20.60
<u>C</u> hronic and convalescent care:		
373	Maximum of 1 visit every 5 days.....	20.60
374	Attendance at high risk deliveries (per infant).....	128.75
381	Detention per ¼ hour.....	30.90
<b>Hospital Out-Patient and Emergency</b>		
401	Consultation .....	55.00
411	<u>P</u> re-dental general assessment.....	51.50
412	<u>G</u> eneral assessment .....	51.50
414	<u>G</u> eneral reassessment .....	36.05
418	<u>R</u> outine post-operative care .....	27.07
421	<u>P</u> artial assessment .....	21.36
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit.....	21.36
<u>P</u> sychotherapy:		
431	Individual, per ½ hour or major part thereof.....	41.20
432	Group (4 to 8 people) per member, per hour or major part thereof .....	6.74
436	Family therapy (2 or more family members) per ½ hour, per family .....	25.75
481	<u>D</u> etention per ¼ hour.....	30.90
482	<u>E</u> scort of a critically ill patient per ¼ hour .....	61.80



CONSULTATIONS AND VISITS

GENERAL PRACTICE

Code		Rate
<b>Physician on Duty at Designated 24 Hour On-Site Emergency Department (see Appendix A)</b>		
401	Consultation.....	55.00
411	Pre-dental general assessment .....	51.50
416	Complex assessment.....	51.50
418	Routine post-operative care.....	27.07
421	Partial assessment.....	21.36
426	Partial assessment of a patient who received a WHSCC service during the same visit .....	21.36
<b>Psychotherapy:</b>		
431	Individual, per ½ hour or major part thereof .....	41.20
432	Group (4 to 8 people) per member, per hour or major part thereof.....	6.74
436	Family therapy (2 or more family members) per ½ hour, per family.....	25.75
481	Detention per ¼ hour .....	30.90

CONSULTATIONS AND VISITS

ANAESTHESIOLOGY

Code Rate

**Fees for Anaesthesiology Consultations and Visit must be coded as capacity "0" on claims.**

**Hospital In-Patient**

301	Consultation .....	110.00
302	Major medical consultation .....	101.81
308	Intraoperative consultation .....	110.00
311	<u>P</u> re-dental general assessment .....	55.16
312	<u>G</u> eneral assessment .....	40.36
313	<u>S</u> pecific assessment .....	33.80
315	<u>S</u> pecific reassessment .....	21.36
381	<u>D</u> etention per ¼ hour .....	30.90

**Hospital Out-Patient and Emergency**

401	Consultation .....	110.00
409	<u>P</u> re-anaesthetic clinic assessment .....	87.55
411	<u>P</u> re-dental general assessment .....	55.16
412	<u>G</u> eneral assessment .....	40.36
413	<u>S</u> pecific assessment .....	33.80
415	<u>S</u> pecific reassessment .....	21.36
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same office visit .....	12.36
481	<u>D</u> etention per ¼ hour .....	30.90
482	<u>E</u> scort of a critically ill patient per ¼ hour .....	61.80

**Hospital Pain Clinic**

These fee codes may only be billed by Anaesthesiologists working in an organized hospital pain clinic approved by the Regional Integrated Health Authority.

400	Pain clinic consultation .....	121.00
419	Pain clinic reassessment .....	36.92

**Pain Clinic Consultation** - This service may only 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

Code		Rate
<b>Office</b>		
101	Consultation .....	78.51
113	Specific assessment .....	41.97
115	Specific reassessment .....	29.16
126	Partial assessment of a patient who received a WHSCC service during the same office visit .....	14.97
181	Detention per ¼ hour .....	33.28
<b>Home</b>		
201	Consultation .....	78.51
213	Specific assessment .....	41.97
215	Specific reassessment .....	29.16
281	Detention per ¼ hour .....	33.28
<b>Hospital In-Patient</b>		
301	Consultation .....	78.51
313	Specific assessment .....	41.97
315	Specific reassessment .....	29.16
<b>Subsequent Visits:</b>		
356	Up to 5 weeks - per diem (visit type 2) .....	24.53
357	6 <sup>th</sup> to 13 <sup>th</sup> week inclusive - per diem (visit type 3) .....	21.10
358	After 13 <sup>th</sup> week - per diem (visit type 4) .....	20.32
<b>Concurrent care. For billing purposes, use subsequent hospital visit codes.</b>		
381	Detention per ¼ hour .....	33.28
<b>Hospital Out-Patient and Emergency</b>		
401	Consultation .....	78.51
413	Specific assessment .....	41.97
415	Specific reassessment .....	29.16
426	Partial assessment of a patient who received a WHSCC service during the same visit .....	13.31
481	Detention per ¼ hour .....	33.28
482	Escort of a critically ill patient per ¼ hour .....	66.55

CONSULTATIONS AND VISITS

EMERGENCY MEDICINE SPECIALIST

Code Rate

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**Hospital Out-Patient and Emergency**

401	Consultation .....	<b>86.33</b>
416	<b>C</b> omplex assessment .....	<b>57.55</b>
421	<b>P</b> artial assessment .....	<b>23.87</b>
426	<b>P</b> artial assessment of a patient who received a WHSCC service during the same visit.....	<b>20.46</b>
481	<b>D</b> etention per ¼ hour.....	<b>34.53</b>
482	<b>E</b> scort of a critically ill patient per ¼ hour .....	<b>69.06</b>

## CONSULTATIONS AND VISITS

## GENERAL, CARDIAC, VASCULAR OR THORACIC SURGERY

Code		Rate
<b>Office</b>		
101	Consultation .....	86.80
103	Trauma consultation .....	149.77
104	Major surgical consultation.....	149.77
113	<u>S</u> pecific assessment .....	53.08
115	<u>S</u> pecific reassessment .....	30.78
126	<u>P</u> artial assessment of a patient who received a WHSCC service during the same office visit.....	15.83
181	<u>D</u> etention per ¼ hour .....	32.26
<b>Home</b>		
201	Consultation .....	86.80
203	Trauma consultation .....	149.77
204	Major surgical consultation.....	149.77
213	<u>S</u> pecific assessment .....	53.08
215	<u>S</u> pecific reassessment .....	30.78
281	<u>D</u> etention per ¼ hour .....	32.26
<b>Hospital In-Patient</b>		
301	Consultation .....	86.80
303	Trauma consultation .....	149.77
304	Major surgical consultation.....	149.77
308	Intraoperative consultation.....	86.80
313	<u>S</u> pecific assessment .....	53.08
315	<u>S</u> pecific reassessment .....	30.78
<u>S</u> ubsequent Visits:		
356	Up to 5 weeks - per diem (visit type 2) .....	24.53
357	6 <sup>th</sup> to 13 <sup>th</sup> week inclusive - per diem (visit type 3) .....	21.10
358	After 13 <sup>th</sup> week - per diem (visit type 4) .....	20.32
<u>C</u> oncurrent care. For billing purposes, use subsequent hospital visit codes.		
381	<u>D</u> etention per ¼ hour .....	32.26
<b>Hospital Out-Patient and Emergency</b>		
401	Consultation .....	86.80
403	Trauma consultation .....	149.77
404	Major surgical consultation.....	149.77
413	<u>S</u> pecific assessment .....	53.08
415	<u>S</u> pecific reassessment .....	30.78
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same office visit.....	14.06
481	<u>D</u> etention per ¼ hour .....	32.26
482	<u>E</u> scort of a critically ill patient per ¼ hour.....	64.52

**CONSULTATIONS AND VISITS**

**INTERNAL MEDICINE**

Code		Rate
<b>Office</b>		
101	Consultation .....	115.21
102	Major medical consultation .....	135.94
112	General assessment .....	70.61
113	Specific assessment .....	60.02
114	General reassessment .....	60.44
115	Specific reassessment.....	36.05
126	Partial assessment of a patient who received a WHSCC service during the same office visit .....	17.38
181	Detention per ¼ hour.....	34.82
190	Geriatric surcharge for patients 65 years of age and older.....	6.90
<b>Home</b>		
201	Consultation .....	115.21
202	Major medical consultation .....	135.94
212	General assessment .....	70.61
213	Specific assessment .....	60.02
214	General reassessment .....	60.44
215	Specific reassessment.....	36.05
281	Detention per ¼ hour.....	34.82
290	Geriatric surcharge for patients 65 years of age and older.....	6.90
<b>Hospital In-Patient</b>		
301	Consultation .....	115.21
302	Major medical consultation .....	135.94
308	Intraoperative consultation .....	115.21
311	Pre-dental general assessment.....	44.13
312	General assessment .....	70.61
313	Specific assessment .....	60.02
314	General reassessment .....	60.44
Subsequent visits:		
356	Up to 5 weeks - per diem (visit type 2) .....	24.53
357	6 <sup>th</sup> to 13 <sup>th</sup> week inclusive - per diem (visit type 3) .....	21.10
358	After 13 <sup>th</sup> week - per diem (visit type 4) .....	20.32
Concurrent care. For billing purposes, use subsequent hospital visit codes.		
381	Detention per ¼ hour.....	34.82
390	Geriatric surcharge for patients 65 years of age and older.....	6.90
<b>Hospital Out-Patient and Emergency</b>		
401	Consultation .....	115.21
402	Major medical consultation .....	135.94
411	Pre-dental general assessment.....	44.13
412	General assessment .....	70.61
413	Specific assessment .....	60.02
414	General reassessment .....	60.44
415	Specific reassessment.....	36.05
426	Partial assessment of a patient who received a WHSCC service during the same office visit .....	17.38
481	Detention per ¼ hour.....	34.82
482	Escort of a critically ill patient per ¼ hour .....	69.64
490	Geriatric surcharge for patients 65 years of age and older.....	6.90

CONSULTATIONS AND VISITS

NUCLEAR MEDICINE SPECIALIST

Code		Rate
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**Hospital In-Patient**

301	Consultation* .....	111.14
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**Hospital Out-Patient and Emergency**

401	Consultation* .....	111.14
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**\*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**

Code		Rate
<b>Office</b>		
101	Consultation .....	119.49
102	Major neurological consultation .....	136.00
112	<u>G</u> eneral assessment .....	63.10
<b>113</b>	<b><u>S</u>pecific assessment .....</b>	<b>53.64</b>
114	<u>G</u> eneral reassessment .....	54.09
115	<u>S</u> pecific reassessment.....	31.05
144	Scheduled interview with parent or teacher for investigation/management of a child's learning disability- per ½ hour or major part thereof.....	52.56
181	<u>D</u> etention per ¼ hour.....	34.87
<b>Home</b>		
201	Consultation .....	119.49
202	Major neurological consultation .....	136.00
212	<u>G</u> eneral assessment .....	63.10
<b>213</b>	<b><u>S</u>pecific assessment .....</b>	<b>53.64</b>
214	<u>G</u> eneral reassessment .....	54.09
215	<u>S</u> pecific reassessment.....	31.05
281	<u>D</u> etention per ¼ hour.....	34.87
<b>Hospital In-Patient</b>		
301	Consultation .....	119.49
302	Major neurological consultation .....	136.00
312	<u>G</u> eneral assessment .....	63.10
<b>313</b>	<b><u>S</u>pecific assessment .....</b>	<b>53.64</b>
314	<u>G</u> eneral reassessment .....	54.09
<u>S</u> ubsequent visits:		
356	Up to 5 weeks - per diem (visit type 2) .....	25.12
357	6 <sup>th</sup> to 13 <sup>th</sup> week inclusive - per diem (visit type 3) .....	21.61
358	After 13 <sup>th</sup> week - per diem (visit type 4) .....	20.81
<u>C</u> oncurrent care. For billing purposes, use subsequent hospital visit codes.		
381	<u>D</u> etention per ¼ hour.....	34.87
<b>Hospital Out-Patient and Emergency</b>		
401	Consultation .....	119.49
402	Major neurological consultation .....	136.00
412	<u>G</u> eneral assessment .....	63.10
<b>413</b>	<b><u>S</u>pecific assessment .....</b>	<b>53.64</b>
414	<u>G</u> eneral reassessment .....	54.09
415	<u>S</u> pecific reassessment.....	31.02
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)

Code		Rate
<b>Office</b>		
101	Consultation .....	119.49
102	Major neurological consultation.....	136.00
112	General assessment .....	63.10
113	Specific assessment .....	53.64
114	General reassessment .....	54.09
115	Specific reassessment .....	31.05
126	Partial assessment of a patient who received a WHSCC service during the same office visit.....	17.05
181	Detention per ¼ hour .....	34.87
<b>Home</b>		
201	Consultation .....	119.49
202	Major neurological consultation.....	136.00
212	General assessment .....	63.10
213	Specific assessment .....	53.64
214	General reassessment .....	54.09
215	Specific reassessment .....	31.05
281	Detention per ¼ hour .....	34.87
<b>Hospital In-Patient</b>		
301	Consultation .....	119.49
302	Major neurological consultation.....	136.00
308	Intraoperative consultation .....	119.49
312	General assessment .....	63.10
313	Specific assessment .....	53.64
314	General reassessment .....	54.09
Subsequent visits:		
356	Up to 5 weeks - per diem (visit type 2) .....	25.12
357	6 <sup>th</sup> to 13 <sup>th</sup> week inclusive - per diem (visit type 3).....	21.61
358	After 13 <sup>th</sup> week - per diem (visit type 4).....	20.81
Concurrent care. For billing purposes, use subsequent hospital visit codes.		
381	Detention per ¼ hour .....	34.87
<b>Hospital Out-Patient and Emergency</b>		
401	Consultation .....	119.49
402	Major neurological consultation.....	136.00
412	General assessment .....	63.10
413	Specific assessment .....	53.64
414	General reassessment .....	54.09
415	Specific reassessment .....	31.02
426	Partial assessment of a patient who received a WHSCC service during the same visit .....	17.05
481	Detention per ¼ hour .....	34.87
482	Escort of a critically ill patient per ¼ hour.....	69.74

## CONSULTATIONS AND VISITS

## NEUROSURGERY

Code		Rate
<b>Office</b>		
101	Consultation .....	108.67
103	Trauma consultation .....	130.24
104	Major surgical consultation .....	130.24
112	<u>G</u> eneral assessment .....	51.05
113	<u>S</u> pecific assessment .....	43.39
114	<u>G</u> eneral reassessment .....	47.22
121	<u>P</u> artial assessment .....	27.03
126	<u>P</u> artial assessment of a patient who received a WHSCC service during the same office visit .....	16.82
181	<u>D</u> etention per ¼ hour .....	34.65
<b>Home</b>		
201	Consultation .....	108.67
203	Trauma consultation .....	130.24
204	Major surgical consultation .....	130.24
212	<u>G</u> eneral assessment .....	51.05
213	<u>S</u> pecific assessment .....	43.39
214	<u>G</u> eneral reassessment .....	47.22
221	<u>P</u> artial assessment .....	27.03
281	<u>D</u> etention per ¼ hour .....	34.65
<b>Hospital In-Patient</b>		
301	Consultation .....	108.67
303	Trauma consultation .....	130.24
304	Major surgical consultation .....	130.24
308	Intraoperative consultation .....	108.67
312	<u>G</u> eneral assessment .....	51.05
313	<u>S</u> pecific assessment .....	43.39
314	<u>G</u> eneral reassessment .....	47.22
	<u>S</u> ubsequent visits:	
356	Up to 5 weeks - per diem (visit type 2) .....	24.53
357	6 <sup>th</sup> to 13 <sup>th</sup> week inclusive - per diem (visit type 3) .....	21.10
358	After 13 <sup>th</sup> week - per diem (visit type 4) .....	20.32
	<u>C</u> oncurrent care. For billing purposes, use subsequent hospital visit codes.	
381	<u>D</u> etention per ¼ hour .....	34.65
<b>Hospital Out-Patient and Emergency</b>		
401	Consultation .....	108.67
403	Trauma consultation .....	130.24
404	Major surgical consultation .....	130.24
412	<u>G</u> eneral assessment .....	51.05
413	<u>S</u> pecific assessment .....	43.39
414	<u>G</u> eneral reassessment .....	47.22
421	<u>P</u> artial assessment .....	25.75
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit .....	16.84
481	<u>D</u> etention per ¼ hour .....	34.65
482	<u>E</u> scort of a critically ill patient per ¼ hour .....	69.30

## CONSULTATIONS AND VISITS

## OBSTETRICS &amp; GYNECOLOGY AND GYNECOLOGICAL ONCOLOGY

Code		Rate
<b>Office</b>		
101	Consultation .....	62.14
104	Major surgical consultation.....	99.85
113	<u>S</u> pecific assessment .....	35.02
115	<u>S</u> pecific reassessment .....	26.51
181	<u>D</u> etention per ¼ hour .....	30.90
<b>Home</b>		
201	Consultation .....	62.14
204	Major surgical consultation.....	99.85
213	<u>S</u> pecific assessment .....	35.02
215	<u>S</u> pecific reassessment .....	26.51
281	<u>D</u> etention per ¼ hour .....	30.90
<b>Hospital In-Patient</b>		
301	Consultation .....	62.14
304	Major surgical consultation.....	99.85
308	Intraoperative consultation .....	62.14
313	<u>S</u> pecific assessment .....	35.02
315	<u>S</u> pecific reassessment .....	24.72
<u>S</u> ubsequent visits:		
356	Up to 5 weeks - per diem (visit type 2) .....	23.64
357	6 <sup>th</sup> to 13 <sup>th</sup> week inclusive - per diem (visit type 3).....	20.33
358	After 13 <sup>th</sup> week - per diem (visit type 4).....	19.58
<u>C</u> oncurrent care. For billing purposes, use subsequent hospital visit codes.		
361	<u>N</u> ewborn baby care in hospital (up to 10 days).....	20.21
381	<u>D</u> etention per ¼ hour .....	30.90
<b>Hospital Out-Patient and Emergency</b>		
401	Consultation .....	62.14
404	Major surgical consultation.....	99.85
413	<u>S</u> pecific assessment .....	35.02
415	<u>S</u> pecific reassessment .....	24.72
481	<u>D</u> etention per ¼ hour .....	30.90
482	<u>E</u> scort of a critically ill patient per ¼ hour.....	61.80

**CONSULTATIONS AND VISITS**

**OPHTHALMOLOGY**

Code		Rate
<b>Office</b>		
101	Consultation* .....	75.27
106	Major ophthalmology consultation .....	127.44
113	<u>S</u> pecific assessment.....	41.13
115	<u>S</u> pecific reassessment.....	28.34
126	<u>P</u> artial assessment of a patient who received a WHSCC service during the same office visit .....	16.14
181	<u>D</u> etention per ¼ hour.....	31.80
<b>Home</b>		
201	Consultation* .....	75.27
213	<u>S</u> pecific assessment.....	41.13
215	<u>S</u> pecific reassessment.....	28.34
281	<u>D</u> etention per ¼ hour.....	31.80
<b>Hospital In-Patient</b>		
301	Consultation* .....	75.27
306	Major ophthalmology consultation .....	127.44
308	Intraoperative consultation .....	75.27
313	<u>S</u> pecific assessment.....	41.13
315	<u>S</u> pecific reassessment.....	28.34
	<u>S</u> ubsequent visits:	
356	Up to 5 weeks - per diem (visit type 2) .....	24.53
357	6 <sup>th</sup> to 13 <sup>th</sup> week inclusive - per diem (visit type 3) .....	21.10
358	After 13 <sup>th</sup> week - per diem (visit type 4) .....	20.32
	<u>C</u> oncurrent care. For billing purposes, use subsequent hospital visit codes.	
381	<u>D</u> etention per ¼ hour.....	31.80
<b>Hospital Out-Patient and Emergency</b>		
401	Consultation* .....	75.27
406	Special ophthalmology consultation .....	127.44
413	<u>S</u> pecific assessment.....	41.13
415	<u>S</u> pecific reassessment.....	28.34
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit .....	14.35
481	<u>D</u> etention per ¼ hour.....	31.80
482	<u>E</u> scort of a critically ill patient per ¼ hour .....	63.60

*\*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 General Practitioner.*

## CONSULTATIONS AND VISITS

## ORTHOPAEDIC SURGERY

Code		Rate
<b>Office</b>		
101	Consultation .....	70.63
103	Trauma consultation .....	111.38
104	Major surgical consultation.....	111.38
105	Back consultation for suspected spinal disorder .....	93.03
113	<u>S</u> pecific assessment .....	39.64
115	<u>S</u> pecific reassessment .....	26.60
126	<u>P</u> artial assessment of a patient who received a WHSCC service during the same office visit.....	15.28
181	<u>D</u> etention per ¼ hour .....	31.93
<b>Home</b>		
201	Consultation .....	70.63
203	Trauma consultation .....	111.38
204	Major surgical consultation.....	111.38
205	Back consultation for suspected spinal disorder .....	93.03
213	<u>S</u> pecific assessment .....	39.64
215	<u>S</u> pecific reassessment .....	26.60
281	<u>D</u> etention per ¼ hour .....	31.93
<b>Hospital In-Patient</b>		
301	Consultation .....	70.63
303	Trauma consultation .....	111.38
304	Major surgical consultation.....	111.38
305	Back consultation for suspected spinal disorder .....	93.03
308	Intraoperative consultation .....	70.63
313	<u>S</u> pecific assessment .....	39.64
315	<u>S</u> pecific reassessment .....	26.60
	<u>S</u> ubsequent visits:	
356	Up to 5 weeks - per diem (visit type 2) .....	24.53
357	6 <sup>th</sup> to 13 <sup>th</sup> week inclusive - per diem (visit type 3).....	21.10
358	After 13 <sup>th</sup> week - per diem (visit type 4).....	20.32
	<u>C</u> oncurrent care. For billing purposes, use subsequent hospital visit codes.	
381	<u>D</u> etention per ¼ hour .....	31.93
<b>Hospital Out-Patient and Emergency</b>		
401	Consultation .....	70.63
403	Trauma consultation .....	111.38
404	Major surgical consultation.....	111.38
405	Back consultation for suspected spinal disorder .....	93.03
413	<u>S</u> pecific assessment .....	39.64
415	<u>S</u> pecific reassessment .....	26.60
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit .....	13.59
481	<u>D</u> etention per ¼ hour .....	31.93
482	<u>E</u> scort of a critically ill patient per ¼ hour.....	63.85

**CONSULTATIONS AND VISITS**

**OTOLARYNGOLOGY**

Code		Rate
<b>Office</b>		
101	Consultation .....	66.63
113	<u>S</u> pecific assessment.....	36.54
115	<u>S</u> pecific reassessment.....	26.82
126	<u>P</u> artial assessment of a patient who received a WHSCC service during the same office visit .....	18.04
181	<u>D</u> etention per ¼ hour.....	31.26
<b>Home</b>		
201	Consultation .....	66.63
213	<u>S</u> pecific assessment.....	36.54
215	<u>S</u> pecific reassessment.....	26.82
281	<u>D</u> etention per ¼ hour.....	31.26
<b>Hospital In-Patient</b>		
301	Consultation .....	66.63
308	Intraoperative consultation .....	66.63
313	<u>S</u> pecific assessment.....	36.54
315	<u>S</u> pecific reassessment.....	24.44
<u>S</u> ubsequent visits:		
356	Up to 5 weeks - per diem (visit type 2) .....	24.53
357	6 <sup>th</sup> to 13 <sup>th</sup> week inclusive - per diem (visit type 3) .....	21.10
358	After 13 <sup>th</sup> week - per diem (visit type 4) .....	20.32
<u>C</u> oncurrent care. For billing purposes, use subsequent hospital visit codes.		
381	<u>D</u> etention per ¼ hour.....	31.26
<b>Hospital Out-Patient and Emergency</b>		
401	Consultation .....	66.63
413	<u>S</u> pecific assessment.....	36.54
415	<u>S</u> pecific reassessment.....	24.44
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit.....	18.04
481	<u>D</u> etention per ¼ hour.....	31.26
482	<u>E</u> scort of a critically ill patient per ¼ hour .....	62.53

## CONSULTATIONS AND VISITS

## PAEDIATRICS (Except Developmental Paediatrics)

Code		Rate
<b>Office</b>		
101	Consultation .....	152.58
102	Major medical consultation.....	157.09
107	Prenatal consultation .....	142.53
112	<u>G</u> eneral assessment .....	98.72
<b>113</b>	<b><u>S</u>pecific assessment.....</b>	<b>93.37</b>
114	<u>G</u> eneral reassessment.....	88.01
115	<u>S</u> pecific reassessment.....	88.01
122	Visit for <u>w</u> ell baby care.....	25.21
141	<u>I</u> nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	62.33
181	<u>D</u> etention per ¼ hour .....	32.12
<b>Home</b>		
201	Consultation .....	152.58
202	Major medical consultation.....	157.09
207	Prenatal consultation .....	142.53
212	<u>G</u> eneral assessment .....	98.72
<b>213</b>	<b><u>S</u>pecific assessment.....</b>	<b>93.37</b>
214	<u>G</u> eneral reassessment.....	88.01
241	<u>I</u> nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	62.33
252	Extra patient seen .....	15.41
281	<u>D</u> etention per ¼ hour .....	32.12
<b>Hospital In-Patient</b>		
301	Consultation .....	152.58
302	Major medical consultation.....	157.09
307	Prenatal consultation .....	142.53
308	Intraoperative consultation.....	152.58
311	<u>P</u> re-dental general assessment .....	43.05
312	<u>G</u> eneral assessment .....	98.72
<b>313</b>	<b><u>S</u>pecific assessment.....</b>	<b>93.37</b>
314	<u>G</u> eneral reassessment.....	88.01
341	<u>I</u> nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit very 3 months)..	62.33
	<u>S</u> ubsequent visits:	
356	Up to 5 weeks - per diem (visit type 2).....	22.82
357	6 <sup>th</sup> to 13 <sup>th</sup> week inclusive - per diem (visit type 3).....	19.63
358	After 13 <sup>th</sup> week - per diem (visit type 4).....	18.90
	<u>C</u> oncurrent care. For billing purposes, use subsequent hospital visit codes.	
361	<u>N</u> ewborn baby care in hospital.....	43.31
374	<u>A</u> ttendance at high risk delivery (per infant).....	126.07
381	<u>D</u> etention per ¼ hour .....	32.12

**CONSULTATIONS AND VISITS**

**PAEDIATRICS (Except Developmental Pediatrics)**

**Code** **Rate**

**Hospital Out-Patient and Emergency**

401	Consultation .....	<b>152.58</b>
402	Major medical consultation .....	<b>157.09</b>
407	Prenatal consultation .....	<b>142.53</b>
411	<u>P</u> re-dental general assessment .....	<b>43.05</b>
412	<u>G</u> eneral assessment .....	<b>98.72</b>
<b>413</b>	<b><u>S</u>pecific assessment .....</b>	<b>93.37</b>
414	<u>G</u> eneral reassessment .....	<b>88.01</b>
415	<u>S</u> pecific reassessment .....	<b>88.01</b>
421	<u>P</u> artial assessment .....	26.24
441	<u>I</u> nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	<b>62.33</b>
481	<u>D</u> etention per ¼ hour .....	<b>32.12</b>
482	<u>E</u> scort of a critically ill patient per ¼ hour .....	<b>64.24</b>

**Physician on Duty at Designated 24 Hour On-Site Emergency Department  
(see Appendix A)**

401	Consultation .....	<b>152.58</b>
402	Major medical consultation .....	<b>157.09</b>
407	Prenatal consultation .....	<b>142.53</b>
411	<u>P</u> re-dental general assessment .....	<b>43.05</b>
<b>413</b>	<b><u>S</u>pecific assessment .....</b>	<b>93.37</b>
415	<u>S</u> pecific reassessment .....	<b>88.01</b>
416	<u>C</u> omplex assessment .....	<b>51.00</b>
421	<u>P</u> artial assessment .....	26.24
441	<u>I</u> nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	<b>62.33</b>
481	<u>D</u> etention per ¼ hour .....	<b>32.12</b>
482	<u>E</u> scort of a critically ill patient per ¼ hour .....	<b>64.24</b>



## CONSULTATIONS AND VISITS

## DEVELOPMENTAL PAEDIATRICS

Code		Rate
<b>Office</b>		
101	Consultation .....	152.58
102	Major medical consultation.....	157.09
107	Prenatal consultation .....	142.53
112	<b>General assessment</b> .....	98.72
113	<b>Specific assessment</b> .....	93.37
114	<b>General reassessment</b> .....	88.01
115	<b>Specific reassessment</b> .....	88.01
122	Visit for <u>w</u> ell baby care .....	25.21
141	<u>I</u> nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	62.33
144	Scheduled <u>i</u> 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 .....	85.36
181	<u>D</u> etention per ¼ hour .....	32.12
<b>Home</b>		
201	Consultation .....	152.58
202	Major medical consultation.....	157.09
207	Prenatal consultation .....	142.53
212	<b>General assessment</b> .....	98.72
213	<b>Specific assessment</b> .....	93.37
214	<b>General reassessment</b> .....	88.01
241	<u>I</u> nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	62.33
252	<u>E</u> xtra patient seen .....	15.41
281	<u>D</u> etention per ¼ hour .....	32.12
<b>Hospital In-Patient</b>		
301	Consultation .....	152.58
302	Major medical consultation.....	157.09
307	Prenatal consultation .....	142.53
311	<u>P</u> re-dental general assessment .....	43.05
312	<b>General assessment</b> .....	98.72
313	<b>Specific assessment</b> .....	93.37
314	<b>General reassessment</b> .....	88.01
341	<u>I</u> nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	62.33
<u>S</u> ubsequent visits:		
356	Up to 5 weeks - per diem (visit type 2).....	22.82
357	6 <sup>th</sup> to 13 <sup>th</sup> week inclusive - per diem (visit type 3).....	19.63
358	After 13 <sup>th</sup> week - per diem (visit type 4).....	18.90
<u>C</u> oncurrent care. For billing purposes, use subsequent hospital visit codes.		
361	<u>N</u> ewborn baby care in hospital.....	43.31
374	<u>A</u> ttendance at high risk delivery (per infant).....	126.07
381	<u>D</u> etention per ¼ hour .....	32.12

CONSULTATIONS AND VISITS

DEVELOPMENTAL PAEDIATRICS

Code		Rate
<b>Hospital Out-Patient and Emergency</b>		
401	Consultation .....	152.58
402	Major medical consultation .....	157.09
407	Prenatal consultation .....	142.53
411	<b>P</b> re-dental general assessment .....	43.05
412	<b>G</b> eneral assessment .....	98.72
<b>413</b>	<b>S</b> pecific assessment .....	93.37
414	<b>G</b> eneral reassessment .....	88.01
415	<b>S</b> pecific reassessment.....	88.01
421	<b>P</b> artial assessment .....	26.24
441	<b>I</b> nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	62.33
481	<b>D</b> etention per ¼ hour.....	32.12
482	<b>E</b> scort of a critically ill patient per ¼ hour .....	64.24

**CONSULTATIONS AND VISITS**

**PHYSICAL MEDICINE**

Code		Rate
<b>Office</b>		
101	Consultation .....	94.42
113	Specific assessment .....	47.39
115	Specific reassessment .....	36.93
126	Partial assessment of a patient who received a WHSCC service during the same office visit .....	15.25
181	Detention per ¼ hour .....	31.83
<b>Home</b>		
201	Consultation .....	94.42
213	Specific assessment .....	47.39
215	Specific reassessment .....	36.93
281	Detention per ¼ hour .....	31.83
<b>Hospital In-Patient</b>		
301	Consultation .....	94.42
313	Specific assessment .....	47.39
315	Specific reassessment .....	36.93
342	Interviewing and counseling of patients and/or relatives, per ½ hour or major part thereof .....	39.53
<b>Subsequent visits:</b>		
356	Up to 5 weeks - per diem (visit type 2) .....	23.66
357	6 <sup>th</sup> to 13 <sup>th</sup> week inclusive - per diem (visit type 3) .....	20.35
358	After 13 <sup>th</sup> week - per diem (visit type 4) .....	19.60
<b>Concurrent care. For billing purposes, use subsequent hospital visit codes.</b>		
375	Physiatric management .....	2.71
381	Detention per ¼ hour .....	31.83
<b>Hospital Out-Patient and Emergency</b>		
401	Consultation .....	94.42
413	Specific assessment .....	47.39
415	Specific reassessment .....	36.93
426	Partial assessment of a patient who received a WHSCC service during the same visit .....	13.55
442	Interviewing and counselling of patients and/or relatives, per ½ hour or major part thereof .....	39.53
475	Physiatric management .....	2.71
481	Detention per ¼ hour .....	31.83
482	Escort of a critically ill patient per ¼ hour .....	63.67

**CONSULTATIONS AND VISITS**

**PLASTIC SURGERY**

Code		Rate
<b>Office</b>		
101	Consultation .....	73.35
104	Major surgical consultation .....	146.72
113	<u>S</u> pecific assessment.....	40.51
115	<u>S</u> pecific reassessment.....	27.83
126	<u>P</u> artial assessment of a patient who received a WHSCC service during the same office visit .....	17.71
181	<u>D</u> etention per ¼ hour.....	32.43
<b>Home</b>		
201	Consultation .....	73.35
204	Major surgical consultation .....	146.72
213	<u>S</u> pecific assessment.....	40.51
215	<u>S</u> pecific reassessment.....	27.83
281	<u>D</u> etention per ¼ hour.....	32.43
<b>Hospital In-Patient</b>		
301	Consultation .....	73.35
304	Major surgical consultation .....	146.72
308	Intraoperative consultation .....	73.35
313	<u>S</u> pecific assessment.....	40.51
315	<u>S</u> pecific reassessment.....	26.88
	<u>S</u> ubsequent visits:	
356	Up to 5 weeks - per diem (visit type 2) .....	24.53
357	6 <sup>th</sup> to 13 <sup>th</sup> week inclusive - per diem (visit type 3) .....	21.10
358	After 13 <sup>th</sup> week - per diem (visit type 4) .....	20.32
	<u>C</u> oncurrent care. For billing purposes, use subsequent hospital visit codes.	
381	<u>D</u> etention per ¼ hour.....	32.43
<b>Hospital Out-Patient and Emergency</b>		
401	Consultation .....	73.35
404	Major surgical consultation .....	146.72
413	<u>S</u> pecific assessment.....	40.51
415	<u>S</u> pecific reassessment.....	26.88
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit.....	15.75
481	<u>D</u> etention per ¼ hour.....	32.43
482	<u>E</u> scort of a critically ill patient per ¼ hour .....	64.85

## CONSULTATIONS AND VISITS

## PSYCHIATRY

Code		Rate
<b>Office</b>		
101	Consultation .....	170.17
113	<b>S</b> pecific assessment .....	68.46
115	<b>S</b> pecific reassessment .....	48.21
126	<b>P</b> artial assessment of a patient who received a WHSCC service during the same office visit.....	14.83
130	<b>P</b> sychiatric care, per ½ hour or major part thereof .....	68.46
<b>P</b> sychotherapy		
131	Individual, per ½ hour or major part thereof .....	68.46
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.....	35.86
137	<b>I</b> nitial interview with parent or guardian (when seen separately) on behalf of emotionally disturbed child.....	56.93
138	<b>C</b> 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 .....	53.74
139	<b>I</b> nterview with child or adolescent - per ½ hour or major part thereof.....	53.36
140	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 .....	53.36
181	<b>D</b> etention per ¼ hour .....	31.11
<b>Home</b>		
201	Consultation .....	170.17
213	<b>S</b> pecific assessment .....	68.46
215	<b>S</b> pecific reassessment .....	48.21
216	<b>S</b> pecific assessment at the lock-up at the custodian's request.....	116.26
230	<b>P</b> sychiatric care, per ½ hour or major part thereof .....	68.46
<b>P</b> sychotherapy		
231	Individual, per ½ hour or major part thereof .....	68.46
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	<b>C</b> 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 .....	53.74
239	<b>I</b> nterview with child or adolescent - per ½ hour or major part thereof.....	53.36
240	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 .....	53.36
252	Extra patient seen .....	12.44
281	<b>D</b> etention per ¼ hour .....	31.11

**CONSULTATIONS AND VISITS**

**PSYCHIATRY**

Code		Rate
<b>Hospital In-Patient</b>		
301	Consultation .....	170.17
313	<u>S</u> pecific assessment.....	68.46
315	<u>S</u> pecific reassessment.....	48.21
330	<u>P</u> sychiatric care, per ½ hour or major part thereof .....	68.46
	<u>P</u> sychotherapy	
331	Individual, per ½ hour or major part thereof .....	68.46
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 .....	56.93
338	<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 .....	53.74
339	<u>I</u> 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 .....	53.36
	<u>S</u> ubsequent visits:	
356	Up to 5 weeks - per diem (visit type 2) .....	26.19
357	6 <sup>th</sup> to 13 <sup>th</sup> week inclusive - per diem (visit type 3).....	22.06
358	After 13 <sup>th</sup> week - per diem (visit type 4).....	21.24
	<u>C</u> oncurrent care. For billing purposes, use subsequent hospital visit codes.	
381	<u>D</u> etention per ¼ hour.....	31.11
<b>Hospital Out-Patient and Emergency</b>		
401	Consultation .....	170.17
413	<u>S</u> pecific assessment.....	68.46
415	<u>S</u> pecific reassessment.....	48.21
426	<u>P</u> artial assessment of a patient who received a WHSCC service during the same visit.....	13.18
430	<u>P</u> sychiatric care, per ½ hour or major part thereof .....	68.46
	<u>P</u> sychotherapy	
431	Individual, per ½ hour or major part thereof .....	68.46
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 .....	56.93
438	<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.....	53.74
439	<u>I</u> 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.....	53.36
476	<u>P</u> sychiatry day care - per visit, per patient.....	22.71
481	<u>D</u> etention per ¼ hour.....	31.11
482	<u>E</u> scort of a critically ill patient, per ¼ hour .....	62.21

*\*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 general practitioner*

CONSULTATIONS AND VISITS

UROLOGY

Code		Rate
<b>Office</b>		
101	Consultation*.....	64.91
104	Major surgical consultation.....	105.86
113	Specific assessment .....	42.35
115	Specific reassessment .....	28.25
126	Partial assessment of a patient who received a WHSCC service during the same office visit.....	18.87
181	Detention per ¼ hour .....	31.42
<b>Home</b>		
201	Consultation*.....	64.91
204	Major surgical consultation.....	105.86
213	Specific assessment .....	42.35
215	Specific reassessment .....	28.25
281	Detention per ¼ hour .....	31.42
<b>Hospital In-Patient</b>		
301	Consultation*.....	64.91
304	Major surgical consultation.....	105.86
308	Intraoperative consultation.....	64.91
313	Specific assessment .....	42.35
315	Specific reassessment .....	28.25
<b>Subsequent visits:</b>		
356	Up to 5 weeks - per diem (visit type 2).....	24.53
357	6 <sup>th</sup> to 13 <sup>th</sup> week inclusive - per diem (visit type 3).....	21.10
358	After 13 <sup>th</sup> week - per diem (visit type 4).....	20.32
<b>Concurrent care. For billing purposes, use subsequent hospital visit codes.</b>		
381	Detention per ¼ hour .....	31.42
<b>Hospital Out-Patient and Emergency</b>		
401	Consultation*.....	64.91
404	Major surgical consultation.....	105.86
413	Specific assessment .....	42.35
415	Specific reassessment .....	28.25
426	Partial assessment of a patient who received a WHSCC service during the same visit .....	14.42
481	Detention per ¼ hour .....	31.42
482	Escort of a critically ill patient per ¼ hour.....	62.84

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

CONSULTATIONS AND VISITS

RADIOLOGY

Code Rate

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**Hospital In-Patient**

301 Consultation\* ..... **115.21**

**Hospital Out-Patient and Emergency**

401 Consultation\* ..... **115.21**

*\*A diagnostic radiology consultation applies when radiographs made elsewhere are referred to a Radiologist for his/her written opinion. It is not payable for the reading of radiographs sent for reporting. As well, a consultation does not apply when the radiographs referred to above are used for comparison purposes with radiographs 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.*



**SURGICAL PROCEDURES**  
**OPERATIONS ON THE NERVOUS SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
98100	Hypothermia - when employed, basic fee for <u>any</u> procedure on nervous system .....				25	25
<b>BRAIN</b>						
<b>Astrocytoma, oligodendroglioma, glioblastoma or metastatic tumour</b>						
	Craniotomy plus excision					
98130	- supratentorial .....		89.87	<b>1342.05</b>	15	15
98132	- infratentorial .....		89.87	<b>1355.23</b>	15	15
98134	Craniotomy plus lobectomy.....		89.87	<b>1231.14</b>	15	15
98136	Microsurgical removal .....			<b>237.36</b>		
<b>Meningioma and other tumourous lesions</b>						
	Craniotomy plus excision					
98138	- supratentorial .....		89.87	<b>1355.23</b>	15	15
98140	- infratentorial plus basal .....		89.87	<b>2106.31</b>	15	15
98142	- microsurgical removal .....			<b>237.36</b>		
98144	- lesion greater than 4 cm. diameter.....			<b>412.18</b>		
98146	- team fee for acoustic neuroma.....			<b>627.65</b>		
<b>Intracranial aneurysm repair</b>						
98150	- carotid circulation .....		89.87	<b>1953.14</b>	15	15
98152	- vertebrobasilar circulation (including aneurysm of vein of Galen).....		89.87	<b>1973.84</b>	15	15
98154	- microsurgical approach .....			<b>237.36</b>		
<b>Cerebral arteriovenous malformation</b>						
	Craniotomy for obliteration and/or excision					
98156	- supratentorial .....		89.87	<b>1953.14</b>	15	15
98158	- infratentorial .....		89.87	<b>1501.30</b>	15	15
98160	- microsurgical approach .....			<b>237.36</b>		
98164	Extracranial approach to include balloon catheter or embolization techniques.....		89.87	<b>873.53</b>	15	15
<b>Extracranial-intracranial microvascular anastomosis</b>						
98168	- superficial temporal artery.....		89.87	<b>1203.09</b>	15	15
98170	- occipital artery .....		89.87	<b>1255.30</b>	15	15
98174	- use of graft (autogenous vessel or synthetic).....			<b>246.00</b>		
<b>Carotid-cavernous fistula</b>						
98178	- intracranial obliteration (to include combined cervical and intracranial procedure) .....		89.87	<b>1254.85</b>	15	15
98180	- extracranial approach.....		89.87	<b>763.30</b>	15	15
<b>Spontaneous Intracerebral Haemorrhage</b>						
	Craniotomy plus removal					
98182	- supratentorial .....		89.87	<b>1174.57</b>	15	15
98184	- infratentorial .....		89.87	<b>1385.05</b>	15	15
98186	Burr hole plus drainage.....		89.87	<b>531.37</b>	15	15

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE NERVOUS SYSTEM**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>BRAIN (Cont'd)</b>					
<b>Intracranial Cyst</b>					
Craniotomy plus evacuation, to include interventriculostomy					
98188				15	15
		89.87	<b>899.87</b>		
98190				15	15
		89.87	<b>1035.52</b>		
98192				15	15
		89.87	<b>407.76</b>		
<b>Brain Abscess</b>					
98194				15	15
		89.87	<b>1174.25</b>		
98196				7	7
		57.19	<b>587.87</b>		
98198				7	7
		57.19	<b>237.36</b>		
<b>Miscellaneous Procedures</b>					
98200				11	11
		89.87	<b>627.65</b>		
98202				15	15
		89.87	<b>1475.09</b>		
98204				15	15
		89.87	<b>1852.37</b>		
98210				15	15
		89.87	<b>1035.40</b>		
98212				15	15
		89.87	<b>743.14</b>		
98216				15	15
		89.87	<b>1061.37</b>		
98222				11	11
		89.87	<b>1377.58</b>		
98232				7	7
		57.19	<b>365.65</b>		
98234				7	7
			<b>192.06</b>		
98236				7	7
			<b>90.49</b>		
98238				7	7
			<b>338.56</b>		
98242					
			<b>136.11</b>		
98244				5	5
		40.85	<b>237.36</b>		
98250				5	5
		40.85	<b>350.45</b>		
98252				5	5
		40.85	<b>237.36</b>		
98254				11	11
		89.87	<b>496.89</b>		
98256					
			<b>265.67</b>		
98260					
			<b>222.64</b>		
98262					
			<b>237.36</b>		
<b>Cranio-Cerebral Injuries</b>					
Reduction of skull fracture					
98272				7	7
		57.19	<b>412.18</b>		
98274				11	11
		89.87	<b>559.68</b>		
98276				4	4
			<b>147.00</b>		
Extracerebral haematoma					
98278				7	7
		57.19	<b>595.70</b>		
98280				11	11
		89.87	<b>880.88</b>		

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE NERVOUS SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>BRAIN (Cont'd)</b>						
<b>Cerebral Injury</b>						
98290	Removal of intracerebral haematoma and/or debridement of traumatized brain (includes management of any skull fracture).....		89.87	<b>971.86</b>	15	15
98292	Removal of foreign body from brain.....		89.87	<b>971.86</b>	15	15
98294	CSF leak - intracranial repair .....		89.87	<b>1069.90</b>	15	15
98296	Decompressive craniectomy (frontal, sub-temporal).....		89.87	<b>627.65</b>	11	11
98298	Subdural tap(s) - unilateral (IOP) .....			<b>58.60</b>		
98300	Diagnostic burr hole(s), uni or bilateral (IOP).....			<b>272.10</b>	7	7
<b>SKULL</b>						
Repair of skull defect:						
98310	- acrylic or metal cranioplasty .....		89.87	<b>570.58</b>	11	11
98314	- replacement of bone flap.....		89.87	<b>484.25</b>	11	11
98316	Skull tumour, excision.....		89.87	<b>412.18</b>	11	11
Craniosynostosis						
Linear Craniectomy						
98318	- 1 suture .....		89.87	<b>474.97</b>	11	11
98320	- multiple sutures.....		89.87	<b>621.36</b>	15	15
Morcellation procedure						
98322	- 1 suture .....		89.87	<b>476.40</b>	11	11
98324	- multiple sutures.....		89.87	<b>750.64</b>	15	15
Lateral canthal advancement						
- unilateral						
98326	- 1 surgeon .....		89.87	<b>767.86</b>	15	15
98328	- 2 surgeons - major portion of surgery .....		89.87	<b>439.79</b>	15	15
98330	- lesser portion of surgery.....			<b>355.43</b>		
- bilateral						
98332	- 1 surgeon .....		89.87	<b>972.48</b>	15	15
98334	- 2 surgeons - major portion of surgery .....		89.87	<b>627.65</b>	15	15
98336	- lesser portion of surgery.....			<b>470.79</b>		
98338	Craniotomy for craniofacial repair .....		89.87	<b>1087.27</b>	15	15
98340	- with repair of frontonasal encephalocele .....			<b>219.79</b>		
<b>ORBIT</b>						
Craniotomy						
98350	- plus removal of orbital tumour .....		89.87	<b>1139.94</b>	15	15
98352	- plus orbital decompression (roof of orbit with or without lateral wall).....		89.87	<b>1066.53</b>	15	15
98354	- for decompression of optic nerve(s) .....		89.87	<b>1139.94</b>	15	15

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE NERVOUS SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>PITUITARY</b>						
98360	Hypophysectomy or excision of tumour, any technique except transphenoidal.....		89.87	1208.17	15	15
98362	Hypophysectomy, transphenoidal, team fee .....		89.87	1190.87	15	15
<b>CAROTID AND VERTEBRAL ARTERIES</b>						
98372	Temporal artery - biopsy, ligation or crysurgery (IOP).....			84.47	4	4
98374	Carotid endarterectomy - with or without bypass .....	81.70		465.50	10	10
98378	- with patch or graft .....	81.70		471.21	10	10
98380	Progressive carotid occlusion by Selverstone clamp (IOP)	81.70		284.65	10	10
<b>CSF SHUNTING PROCEDURES</b>						
98390	Lumbo-peritoneal shunt.....	89.87		502.69	11	11
98392	- revision peritoneal end.....	89.87		<b>281.70</b>	7	7
98394	- revision lumbar end .....	89.87		<b>281.70</b>	7	7
98396	- revision entire shunt.....	89.87		<b>521.15</b>	7	7
98398	Meningocoele-peritoneal shunt .....	89.87		453.17	11	11
98400	Ventriculo-peritoneal shunt.....	89.87		557.33	11	11
98402	- revision ventricular end.....	89.87		507.26	7	7
98404	- revision peritoneal end.....	89.87		507.26	7	7
98406	- revision entire shunt.....	89.87		493.55	7	7
98408	Ventriculo-atrial shunt.....	89.87		796.67	11	11
98410	- revision ventricular end.....	89.87		278.96	7	7
98412	- revision atrial end.....	89.87		278.96	7	7
98414	- revision entire shunt.....	89.87		<b>474.45</b>	7	7
98416	- removal.....	89.87		203.11	7	7
98420	Insertion CSF reservoir (Ommaya including burr holes)....	89.87		301.27	11	11
98422	Third ventriculostomy .....	89.87		645.02	11	11
<b>CRANIAL NERVES</b>						
98430	Percutaneous coagulation of gasserian (trigeminal) ganglion or root - unilateral .....	89.87		402.91	11	11
98432	Decompression gasserian ganglion .....	89.87		473.70	11	11
	Rhizotomy or differential section trigeminal nerve					
98434	- temporal approach.....	89.87		473.70	11	11
98436	- posterior fossa approach .....	89.87		1021.89	11	11
98438	- avulsion supraorbital nerve.....	32.68		168.20	4	4
98440	- avulsion infraorbital nerve.....	32.68		168.20	4	4
98442	- avulsion mandibular nerve.....	32.68		195.34	4	4

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE NERVOUS SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>CRANIAL NERVES (Cont'd)</b>						
98446	Anastomosis hypoglossal to facial nerve .....		49.02	553.93	6	6
98450	Occipital and/or suboccipital craniectomy for compression, decompression or section of cranial nerves .....		89.87	1021.89	11	11
98452	Division vestibular nerve .....		89.87	946.19	11	11
98454	Division of glossopharyngeal nerve .....		49.02	946.19	6	6
98456	Division of nerves to sternomastoid in neck.....		49.02	305.60	6	6
<b>PERIPHERAL NERVES</b>						
98470	Biopsy and/or avulsion of peripheral nerve (IOP) .....		24.51	99.95	4	4
	Brachial plexus exploration					
98472	- in posterior triangle.....		49.02	342.41	6	6
98474	- in axilla .....		49.02	348.38	6	6
98476	- in posterior triangle and axilla.....		49.02	471.21	6	6
98478	Decompression by scalenotomy .....		49.02	235.60	6	6
98480	- excision of cervical rib .....		81.70	428.01	6	6
98482	Exploration of major nerve (median, ulna, radial, sciatic, etc.) with or without neurolysis .....		32.68	191.62	6	6
98484	Removal tumour major peripheral nerve.....		32.68	279.87	4	4
	Suture of major peripheral nerve					
98486	- epineural repair .....		32.68	271.46	4	4
98488	- fascicular technique, first fascicle .....		32.68	325.56	4	4
98490	- each additional fascicle repaired .....			54.98		
	Graft of major peripheral nerve					
98492	- epineural grafting.....		32.68	445.50	4	4
98494	- fascicular grafting, first fascicle .....		32.68	491.20	4	4
98496	- each additional fascicle grafted .....			109.95		
	Suture or decompression of small peripheral nerve (e.g., digital)					
98498	- epineural technique.....		24.51	171.63	4	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 .....		24.51	99.95	4	4
98504	- fascicular technique, including first fascicle. Use fee code 98496 to claim additional fascicles grafted ...			109.95		
98506	Delayed repair of graft (more than 4 weeks from date of injury),.....			105.66		
98508	Microsurgical technique used .....			254.00		
98510	Decompression median nerve at wrist.....		24.51	<b>191.62</b>	4	4
98512	Decompression ulnar nerve at elbow.....		24.51	128.51	4	4
98514	Transposition of ulnar nerve at elbow .....		24.51	235.60	4	4
98516	Decompression lateral femoral cutaneous nerve.....		32.68	139.93	4	4
98518	Division obturator nerve .....		49.02	235.60	6	6
98520	Morton's neuroma - excision.....		32.68	157.07	4	4
98522	Excision of glomus tumour (IOP) .....			99.10	4	4
98524	Neuroma - single, subcutaneous (IOP).....			99.10	4	4
98528	Implantation of electrode for peripheral nerve stimulation (IOP).....		24.51	104.24	4	4

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE NERVOUS SYSTEM**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>AUTONOMIC NERVOUS SYSTEM</b>					
Sympathectomy					
98540	Cervical .....	49.02	314.14	6	6
98542	Cervicodorsal - unilateral.....	81.70	314.14	10	10
98546	- thoracic approach .....	106.21	314.14	13	13
98548	Lumbar - unilateral.....	49.02	279.87	6	6
98550	- bilateral.....	49.02	414.09	6	6
<b>SPINAL CORD AND NERVE ROOTS</b>					
For operations on the spinal cord and nerve roots, the basic Assistants' and Anaesthesiologists' fees will depend on the surgical approach					
98570	- cervical .....	65.36		10	10
98572	- dorsal or lumbar.....	57.19		8	8
Tumours - partial or total					
98580	- extradural.....		980.43		
98582	- intradural (extramedullary).....		1242.00		
98584	- 3 segments or more..... add Intramedullary		175.74		
98590	- biopsy and/or decompression.....		451.48	9	9
98592	- removal.....		1563.52	12	12
98594	- 3 segments or more..... add		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.....		1563.52		
98606	- 3 segments or more..... add		192.88		
98608	- with operating microscope..... add		262.81		
98612	Insertion/revision of implantable infusion pump.....		510.00		
98616	Implantation of permanent subcutaneous reservoir including laminectomy.....		510.00		
<i>Note: 98616 is not eligible for payment when rendered with any decompressive codes.</i>					
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**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>SPINAL CORD AND NERVE ROOTS (Cont'd)</b>					
Laminectomy and decompression of spinal cord					
98632			432.55		
98634			594.75		
With fusion by same surgeon					
98638			264.93		
98640			333.41		
Fusion by separate surgeon					
98644			353.24		
98646			410.91		
98648			219.87		
98650			201.85		
98656			1146.55		
98658			243.35		
98664			594.75		
98668			1175.17		
98676			787.62		
98678			192.88		
98679			262.81		
98680			583.93		
98682			700.70		
98684			460.19		
98686			309.84		
98688			75.00		
98690			88.03		
98700			100.92	4	4
98702			32.44		
98704			25.18		

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE ENDOCRINE SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>THYROID GLAND</b>						
<b>Incision</b>						
98010	Aspiration, thyroid cyst (IOP) .....			16.35		
98012	Biopsy, needle (IOP).....			27.25	6	6
98014	Abscess, complete care.....			70.85	4	4
<b>Excision</b>						
Biopsy						
98020	- surgical.....		49.02	202.85	6	6
Thyroidectomy						
98022	- total .....		49.02	<b>615.90</b>	8	8
98024	- subtotal.....		49.02	552.75	7	7
98026	- hemi .....		49.02	385.93	7	7
98028	Excision of solitary nodule .....		49.02	289.10	6	6
<b>PARATHYROID, THYMUS AND ADRENAL GLANDS</b>						
<b>Excision</b>						
98040	Exploration and/or removal, parathyroids or parathyroid tumour .....		49.02	576.20	8	8
98042	- if requiring splitting of sternum .....		106.21	632.46	13	13
98044	Thymectomy .....		106.21	689.38	13	13
98046	Adrenalectomy or exploration, unilateral.....		81.70	402.00	10	10
98048	- bilateral, with or without oophorectomy .....		81.70	<b>623.10</b>	11	11
98050	Pheochromocytoma.....		98.04	<b>537.00</b>	13	13
98052	Thymus transplant (IOP).....			44.69	4	4



## SURGICAL PROCEDURES

## OPERATIONS ON THE FEMALE GENITAL SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. 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.					
	<b>VULVA</b>					
	<b>Incision</b>					
97660	Hymenotomy.....			32.56	4	4
	Abscess of vulva, Bartholin or Skene's gland (IOP)					
97662	- local anaesthetic .....	10.61		11.79		
97664	- general anaesthetic.....			44.91	4	4
97668	Perineotomy (IOP).....			22.45		
	<b>Excision</b>					
97674	Hymenectomy (with or without perineotomy).....			50.52	4	4
	Vulvectomy					
97676	- simple - partial or total.....		32.68	148.20	4	4
97678	- radical					
	- without gland dissection - partial or complete resection.....		49.02	316.09	6	6
97680	- with complete dissection of glands - uni or bilateral.....		49.02	546.75	7	7
97682	Cyst of Bartholin's gland.....		24.51	89.82	4	4
97684	Marsupialization of cyst (IOP).....	40.42		44.91	4	4
	Condylomata - single or multiple (IOP)					
97686	Chemical - 1 .....	5.05		5.61		
97688	- 2 .....	7.59		8.43		
97690	- 3 or more .....	10.11		11.23		
	Surgical excision or electrodesiccation					
97692	- local anaesthetic.....	22.50		25.00		
97694	- general anaesthetic.....			70.00	4	4
97696	Cryosurgery - initial or subsequent treatment.....	13.50		15.00		
	Laser destruction of vulval lesions					
97698	- local anaesthetic .....			22.40		
97700	- general anaesthetic.....			94.50	4	4
	<b>Repair</b>					
97710	Non-obstetrical injury to vulva and/or vagina, and/or perineum .....		IC	IC	IC	IC
97712	Ligation of varicose vein of labia - uni or bilateral .....			44.91	4	4
	<b>VAGINA</b>					
	<b>Endoscopy (IOP)</b>					
97716	Colpomicroscopy of vagina (includes cervix).....			60.00	4	4
97718	- with biopsy and/or endocervical curettage .....			80.00	4	4

## SURGICAL PROCEDURES

## OPERATIONS ON THE FEMALE GENITAL SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>VAGINA (Cont'd)</b>						
<b>Incision</b>						
97720	Colpotomy, posterior, drainage or needle puncture .....			41.54	4	4
97722	Culdotomy, incision and exploration.....		24.51	81.96	4	4
97724	Culdoscopy including biopsy (IOP).....			61.75	4	4
97726	Incision and drainage of cyst, abscess or haematoma.....	28.30		31.44	4	4
<b>Excision</b>						
Biopsy(s) - when sole procedure (IOP)						
97730	- local anaesthetic.....	12.13		13.47		
97732	- general anaesthetic .....			31.44	4	4
97734	Local excision of cyst .....		24.51	89.82	4	4
97736	Excision of congenital vaginal septum.....		24.51	90.38	4	4
97738	Colpectomy, partial or complete, for non-malignant lesions (not to be used to claim for biopsy).....		32.68	255.98	6	6
97740	Colpectomy, radical for malignancy.....		65.36	480.00	8	8
97742	Laser treatment of vagina under general anaesthesia .....			150.00	4	4
<b>Repair</b>						
97750	Cystocoele or rectocoele.....		24.51	150.00	5	5
97752	Cystocoele and rectocoele .....		24.51	225.00	5	5
97754	Cystocoele, rectocoele and enterocele .....		24.51	225.00	5	5
97756	Rectocoele and enterocele.....		24.51	210.00	5	5
97758	Cystocoele, rectocoele and prolapse (Fothergill) .....		24.51	222.29	5	5
97760	Cystocoele, rectocoele and excision cervical stump .....		24.51	224.54	6	6
97762	Vaginal vault prolapse (post hysterectomy) or enterocele .....		24.51	254.00	6	6
97768	Rectocoele and repair of anal sphincter .....		24.51	202.09	5	5
97770	Perineorrhaphy.....		24.51	67.36	4	4
97772	Colpocleisis .....		40.85	177.39	5	5
97774	Operation for artificial vagina.....		32.68	235.77	6	6
Closure of fistula						
- vesico-vaginal						
97776	- 1 surgeon.....		32.68	263.83	6	6
97778	- 2 surgeons - vaginal surgeon .....		32.68	196.47	6	6
97780	- abdominal surgeon .....			196.47		
97782	- recto-vaginal (any repair).....		32.68	362.89	6	6
97784	- uretero-vaginal.....		49.02	280.68	6	6
97786	- urethro-vaginal.....		32.68	129.11	4	4
97788	Urethral caruncle or prolapse of mucosa.....			59.50	4	4
97790	Retropubic urethropexy for stress incontinence .....		32.68	<b>301.35</b>	5	5
Combined abdominal - vaginal procedure for stress incontinence						
97794	- 1 surgeon.....		49.02	<b>301.35</b>	7	7
97796	- 2 surgeons - vaginal surgeon .....		49.02	123.50	7	7
97798	- abdominal surgeon .....			215.56		
<b>Manipulation</b>						
97808	Examination and/or dilation - general anaesthetic (IOP) ...			28.07	4	4

## SURGICAL PROCEDURES

## OPERATIONS ON THE FEMALE GENITAL SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>FALLOPIAN TUBE</b>						
<b>Excision (unilateral or bilateral)</b>						
97820	Salpingectomy and salpingo - oophorectomy .....		49.02	262.41	6	6
97822	Partial salpingectomy for sterilization.....		49.02	112.27	6	6
<b>Repair</b>						
Tubal plastic operation						
97830	- fimbriolysis - unilateral.....		49.02	132.48	6	6
97832	- salpingostomy - unilateral.....		49.02	188.61	6	6
97834	- resection with reanastomosis .....		49.02	246.99	6	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).....		65.36	509.60	8	8
<b>Suture</b>						
97844	Ligation of tubes, all methods, all approaches .....	181.59	49.02	201.77	6	6
<b>OVARY</b>						
<b>Excision (uni or bilateral)</b>						
97850	Biopsy of ovaries by laparotomy .....		40.85	<b>257.05</b>	6	6
97852	Wedge resection of ovaries (e.g. Stein-Leventhal) .....		40.85	<b>257.05</b>	6	6
97854	Oophorectomy .....		49.02	<b>305.90</b>	6	6
97856	Oophorectomy with omentectomy for malignant disease...		49.02	<b>410.40</b>	6	6
97858	Oophorocystectomy .....		49.02	<b>305.90</b>	6	6
97860	Para ovarian cyst .....		49.02	<b>305.90</b>	6	6
97862	Oophorectomy with or without omentectomy for malignant disease and with pelvic and/or perioaortic lymphadenectomy .....		49.02	<b>884.85</b>	6	6
97864	Second look exploratory laparotomy including biopsies, when done as part of chemotherapy protocol for ovarian carcinoma with or without total omentectomy ..		49.02	<b>431.45</b>	6	6
97866	Culdectomy (extensive removal of pelvic peritoneum required for evacuation of malignancy extension of secondaries).....		49.02	200.00	6	6
<b>UTERUS AND CERVIX UTERI</b>						
<b>Endoscopy (IOP)</b>						
97870	Colpomicroscopy (includes vagina) .....			60.00	4	4
97872	- with biopsy and/or endocervical curettage .....			80.00	4	4
97874	Hysteroscopy .....			111.02		
97876	- with biopsy .....			124.89		
97878	- with cannulization of tubes .....			131.55		

**SURGICAL PROCEDURES**

**OPERATIONS ON THE FEMALE GENITAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>UTERUS AND CERVIX UTERI (Cont'd)</b>						
<b>Incision</b>						
97890	Endometrial biopsy (IOP) .....	26.10		29.00		
97892	Biopsy, cervix (IOP).....	9.80		10.89	4	4
97910	Hysterotomy .....		49.02	185.25	6	6
97914	Cryoconization, electroconization with or without endocervical curettage (IOP) .....			25.82	4	4
97916	CO <sub>2</sub> laser therapy with or without curettage for CIN (Cervical Intra-epithelial Neoplasia) (IOP).....			51.64	4	4
<b>Excision</b>						
<b>NOTE: D &amp; Cs are <u>not</u> billable in addition to code 97926 or 97928.</b>						
Diagnostic curettage						
97920	- (with or without cauterization biopsy of cervix, removal of polypi or Rubin's test) (IOP) .....	58.50		65.00	4	4
97922	- and hystero-salpingography (IOP) .....			65.00	4	4
97924	- with knife conization of cervix (includes <u>additional</u> biopsies) .....		24.51	132.35	4	4
Therapeutic hysteroscopy/endometrial ablation						
97926	- initial .....			207.00	6	6
97928	- repeat procedure within 1 year .....			145.00	6	6
Hysterectomy (with or without adnexa or enterocoele)						
97930	Total, abdominal or vaginal .....		49.02	355.30	6	6
97932	- with cystocoele and rectocoele .....		49.02	473.73	6	6
97934	- with cystocoele or rectocoele.....		49.02	414.52	6	6
97938	Partial or subtotal .....		49.02	266.41	6	6
97940	- with cystocoele and rectocoele.....		49.02	334.91	6	6
97942	- with cystocoele or rectocoele.....		49.02	289.24	6	6
97948	Radical (total hysterectomy plus lymphadenectomy) .....		65.36	620.70	8	8
97950	Myomectomy .....		49.02	185.25	6	6
97952	Amputation of cervix.....		32.68	123.50	4	4
97954	Cervical stump - abdominal .....		49.02	157.18	6	6
97956	- vaginal .....		32.68	166.16	4	4
<b>Introduction (IOP)</b>						
97960	Insufflation - Rubin's test .....			26.94	4	4
97962	Insufflation and endometrial biopsy .....			43.19	4	4
97964	Insertion of IUCD .....	26.27		29.19		
<b>Repair</b>						
97970	Hysteropexy (uterine suspension).....		49.02	145.95	6	6
97972	- with anterior and posterior repair .....		49.02	235.77	6	6
97974	- with anterior or posterior repair .....		49.02	190.86	6	6
97976	Cervix, incompetent.....		24.51	80.83	4	4
97978	Trachelorrhaphy (plastic repair of cervix) - not immediately following delivery.....		24.51	61.75	4	4
97982	Hysteroplasty - excision of septum (Strassman) .....		49.02	196.47	6	6
97984	Unification of double uteri.....		32.68	255.98	4	4
97986	Uterine inversion - manual .....	85.89		95.43	4	4
97988	- operative .....		32.68	196.47	6	6
97990	Presacral neurectomy .....		49.02	196.47	6	6

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE FEMALE GENITAL SYSTEM**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>UTERUS AND CERVIX UTERI (Cont'd)</b>					
<b>Cautery of Cervix (IOP)</b>					
Office					
97994					
97996					

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MALE GENITAL SYSTEM**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>PENIS</b>					
<b>Incision</b>					
Slit of prepuce					
97410			7.69		
97412			7.56	4	4
97414	13.84		15.38	4	4
<b>Excision</b>					
Circumcision					
97422	18.72		20.80	4	4
97424	135.18		150.20	4	4
97426			13.86	4	4
Biopsy (IOP) .....					
Amputation					
97428		32.68	103.99	4	4
97430		32.68	271.52	5	5
97432		49.02	346.62	7	7
Condylomata (IOP)					
97434	17.68		19.64		
97436			47.37	4	4
97438		32.68	167.53	4	4
<b>Repair</b>					
<b>Hypospadias or Epispadias</b>					
<b>One Stage Repair</b>					
97441		49.02	287.75	6	6
97443		49.02	383.50	6	6
97444		49.02	662.45	6	6
97446		32.68	215.80	4	4
97448		32.68	205.66	4	4
97450			69.32	4	4
97452		32.68	299.24	4	4
97454			53.74		
97456		32.68	107.48	4	4
97460			27.14		
<b>TESTIS</b>					
<b>Incision</b>					
97470			33.51	4	4
97472			34.66	4	4
97474			48.53	4	4
97476			68.17	4	4
97478		24.51	106.30	4	4
97480		49.02	344.31	8	8
97482		24.51	128.25	4	4

## SURGICAL PROCEDURES

## OPERATIONS ON THE MALE GENITAL SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>TESTIS (Cont'd)</b>						
<b>Repair</b>						
97490	Orchidopexy, any type, <b>any stage</b> .....		32.68	<b>331.70</b>	4	4
97494	Exploration for undescended testicle, without orchidopexy .....		32.68	<b>260.85</b>	4	4
97496	Reduction of torsion of testis or appendix testis and repair .....		24.51	<b>235.35</b>	4	4
97498	Ruptured testicle .....		24.51	<b>170.65</b>	4	4
<b>97500</b>	<b>Insertion of testicular prosthesis.....</b>		<b>49.02</b>	<b>170.65</b>	<b>6</b>	<b>6</b>
<i>Note: Insertion of testicular prosthesis at the time of orchidectomy is not eligible for payment.</i>						
<b>EPIDIDYMIS</b>						
<b>Incision</b>						
97510	Abscess (IOP) .....			<b>34.66</b>	4	4
<b>Excision</b>						
97520	Spermatocoele .....		24.51	<b>103.99</b>	4	4
97522	Epididymectomy - unilateral .....		24.51	<b>103.99</b>	4	4
97524	Anastomosis epididymovasostomy .....		24.51	<b>103.99</b>	4	4
<b>TUNICA VAGINALIS</b>						
<b>Incision</b>						
97530	Hydrocoele aspiration (IOP) .....	<b>6.24</b>		<b>6.93</b>		
<b>Excision</b>						
97536	Hydrocoele - unilateral .....		32.68	<b>109.76</b>	4	4
<b>SCROTUM</b>						
<b>Incision</b>						
97540	Abscess or haematocoele (IOP) .....			<b>34.66</b>	4	4
97544	- and exploration - unilateral .....		24.51	<b>69.32</b>	4	4
<b>Excision</b>						
97550	Minor lesions, e.g., sebaceous cysts, fibromata, etc. ....			<b>47.95</b>	4	4
97552	Resection of scrotum.....		24.51	<b>136.34</b>	4	4
<b>Suture</b>						
97556	Trauma-laceration - depending on extent and complications .....		IC	IC	IC	IC

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MALE GENITAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>VAS DEFERENS</b>						
<b>Incision</b>						
97560	Vasography (IOP) .....			<b>33.51</b>	4	4
<b>Repair</b>						
97564	Anastomosis, unilateral.....		24.51	<b>136.34</b>	4	4
97566	- including biopsy and vasography .....		24.51	<b>171.00</b>	4	4
<i>Note: Reconstruction following previous sterilization procedures is <u>not</u> an insured service.</i>						
<b>Suture</b>						
97580	Ligation - bilateral (IOP).....	<b>101.90</b>	24.51	<b>113.22</b>	4	4
<b>SPERMATIC CORD</b>						
<b>Excision</b>						
97590	Hydrocoele - single .....		24.51	<b>103.99</b>	4	4
97592	Varicocele - single .....		24.51	<b>103.99</b>	4	4
<b>SEMINAL VESICLES</b>						
<b>Incision</b>						
97600	Abscess (IOP).....			<b>68.17</b>	4	4
<b>Excision</b>						
97606	Vesiculectomy.....		24.51	<b>550.84</b>	4	4
<b>PROSTATE</b>						
<b>Incision</b>						
97610	Biopsy - needle (IOP).....			<b>66.08</b>	4	4
97611	- with ultrasound guidance.....add			<b>75.10</b>		
97612	- with drainage abscess (IOP) .....		32.68	<b>73.94</b>	4	4
97618	Biopsy, perineal, open .....		32.68	<b>172.68</b>	4	4



**SURGICAL PROCEDURES**

**OPERATIONS ON THE MALE GENITAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>PROSTATE (Cont'd)</b>						
<b>Excision</b>						
Prostatectomy (not to include investigative cystoscopy but to include vasectomy when indicated)						
97620	Perineal .....		49.02	<b>272.67</b>	6	6
97622	Perineal with vesiculectomy .....		49.02	<b>411.32</b>	11	11
97624	Suprapubic - 1 stage .....		40.85	<b>288.85</b>	5	5
97626	- 2 stages - 1 <sup>st</sup> stage .....		40.85	<b>136.34</b>	5	5
97628	- 2 <sup>nd</sup> stage .....		40.85	<b>171.00</b>	5	5
97630	Retropubic - simple .....		40.85	<b>288.85</b>	5	5
97632	- radical .....		40.85	<b>649.48</b>	5	5
97634	Transpubic total prostatovesiculectomy with pelvic lymph node dissection.....		65.36	<b>496.82</b>	11	11
97636	Staging pelvic lymphadenectomy for prostatic cancer .....		57.19	<b>182.55</b>	7	7
<b>Endoscopy (Cystoscopy included)</b>						
97640	Transurethral electrosection.....			<b>486.78</b>	5	5
97642	Transurethral drainage of abscess, complete care.....			<b>68.17</b>	5	5

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE UROGENITAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>KIDNEYS AND PERINEPHRUM</b>						
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.					
<b>Percutaneous Procedures (IOP)</b>						
96802	Percutaneous nephrostomy .....			144.79		
96804	Insertion of stent .....			103.35		
96806	Dilation of tract.....			129.26		
96808	Selective catheterization of calyces .....			70.99		
96810	Nephroscopy.....			129.26		
96812	Removal of renal calculi.....		40.85	226.16	6	6
96814	- if disintegrated by ultrasound .....			129.26		
<b>Incision</b>						
96820	Renal biopsy, needle (IOP).....			83.41	4	4
96822	Drainage of kidney abscess.....	57.19		213.64	7	7
96824	Drainage of perinephric abscess .....	57.19		128.62	7	7
96826	Exploration of renal and perirenal tissues with or without biopsy or unroofing of cyst.....	57.19		207.10	7	7
<b>Nephrotomy</b>						
96828	- with drainage - nephrostomy .....	57.19		207.10	7	7
96832	- with removal of calculus .....	57.19		272.50	7	7
96836	Transection of aberrant renal vessels .....	57.19		226.72	7	7
96838	Pyelotomy - with drainage .....	57.19		213.64	7	7
96840	- with removal of calculus .....	57.19		256.15	7	7
96842	- with diversion of urine.....	57.19		259.42	7	7
<b>Excision</b>						
96850	Calycectomy with diversion of urine.....	57.19		432.00	7	7
96852	Hemi-nephrectomy .....	57.19		470.47	7	7
96854	Partial or hemi-nephrectomy with total ureterectomy .....	57.19		487.10	7	7
<b>Nephrectomy</b>						
96860	- simple.....	57.19		<b>467.00</b>	7	7
<b>96865</b>	<b>- thoraco-abdominal or radical nephrectomy with or without gland dissection .....</b>	<b>106.21</b>		<b>875.00</b>	<b>13</b>	<b>13</b>
96868	- partial nephrectomy for malignancy.....	106.21		<b>697.95</b>	13	13
96872	Nephro-ureterectomy, total, without resection of ureterovesical junction.....	57.19		305.20	10	10
96874	Nephro-ureterectomy, total, with resection of ureterovesical junction.....	57.19		329.18	10	10
96876	Excision of stenosed renal artery with reimplantation or homograft .....	57.19		414.20	15	15

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE UROGENITAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>KIDNEYS AND PERINEPHRUM (Cont'd)</b>						
<b>Repair</b>						
96880	Pyeloplasty.....		57.19	376.20	7	7
96884	Nephropexy .....		57.19	226.72	7	7
96886	Renal sympathectomy.....		57.19	257.24	7	7
96888	Symphysiotomy, for horseshoe kidney with or without nephropexy and associated procedures. ....		57.19	259.42	7	7
<b>Suture</b>						
96894	Ruptured or lacerated kidney - repair or removal .....		57.19	257.24	7	7
<b>Litholapaxy</b>						
96900	Staghorn (pelvic) with lithotripsy under x-ray control.....		57.19	381.50	9	9
<b>Extra Renal Procedures</b>						
96910	Excision of retroperitoneal tumour.....		57.19	226.72	7	7
96912	Exploration of retroperitoneal tumour .....		57.19	178.22	7	7
96914	Sacro-coccygeal teratoma.....		49.02	259.42	6	6
96916	Renal hypothermia - extra .....			32.70		
<b>Extracorporeal Shock Wave Lithotripsy (IOP)</b>						
96918	- unilateral, any mode, per session, per patient .....			313.19	6	6
96920	- bilateral, any mode, per session, per patient .....			558.00	6	6
<b>Kidney Transplants</b>						
96940	Kidney transplant (team fees, these fees <u>do not</u> include immunosuppressive therapy, which is on a fee-for- service basis .....			555.90	13	13
96944	Donor nephrectomy (extra) team fee, uni or bilateral .....		57.19	1050.00	16	16
96948	Renal autotransplantation .....			467.61	10	10

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE UROGENITAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>URETER</b>						
<b>Incision</b>						
96970	Peri-ureteral abscess .....		49.02	130.80	6	6
	Ureterotomy, abdominal or vaginal exploratory or for drainage					
96972	- upper 2/3 .....		49.02	163.50	6	6
96974	- lower 1/3.....		49.02	226.72	6	6
	with removal of calculus					
96976	- upper 2/3 .....		49.02	218.00	6	6
96978	- lower 1/3.....		49.02	277.95	6	6
	where ureter has been previously opened					
96980	- upper 2/3 .....		49.02	244.16	6	6
96982	- lower 1/3.....		49.02	289.94	6	6
<b>Excision</b>						
	Ureterectomy					
96990	- including ureterovesical junction .....		57.19	285.28	7	7
96992	- other .....		57.19	211.48	7	7
<b>Repair</b>						
97000	Trimming of ureter .....		49.02	257.24	6	6
97002	Uretero-vesical anastomosis or reimplantation - unilateral		49.02	461.40	8	8
97004	Bifid ureter .....		49.02	272.50	8	8
97006	Uretero-ileal conduit.....		49.02	457.80	9	9
97008	Uretero-ileal conduit with total cystectomy.....		49.02	512.06	15	15
97010	Uretero-ileal conduit with ureterectomy and ileal replacement.....		49.02	453.44	7	7
97012	Uretero-intestinal anastomosis or transplant - unilateral		49.02	194.02	6	6
97018	Uretero-ureterostomy.....		49.02	352.87	8	8
97020	Ureterostomy, cutaneous, unilateral .....		49.02	161.32	6	6
97024	Uretero-vaginal fistula .....		49.02	327.00	6	6
97026	Ureterolysis for periureteral fibrosis - unilateral.....		49.02	257.24	6	6
97028	Ureteroplasty (Hutch), unilateral .....		49.02	194.02	6	6
97030	Bladder flap (Baori) .....		49.02	261.60	6	6
<b>Suture</b>						
	Spontaneous/traumatic rupture or transection					
97040	- immediate - upper 2/3 .....		49.02	226.72	6	6
97042	- lower 1/3.....		49.02	257.24	6	6
97044	- late repair - upper 2/3 .....		49.02	257.24	6	6
97046	- lower 1/3.....		49.02	292.12	7	7
<b>Endoscopic Procedures</b>						
97050	Calibration and/or dilation - 1 or both sides.....			166.26	4	4
97052	Manipulation and/or removal of calculus including ureteral meatotomy if required.....			166.26	4	4
	Cystoscopy and diagnostic ureteroscopy above					
97054	Intramural ureter (IOP).....			169.32	4	4
97056	- with removal of calculus .....			226.16		
97058	- if disintegrated by ultrasound .....			129.26		

## SURGICAL PROCEDURES

## OPERATIONS ON THE UROGENITAL SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>BLADDER</b>						
<b>Endoscopy-Cystoscopy</b>						
<b>Diagnostic Procedures, includes dilation for access (IOP)</b>						
<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 .....	86.09		95.66	4	4
97072	Repeat within 30 days .....	43.05		47.83	4	4
97078	With transurethral biopsy, brush biopsy of renal pelvis and/or ureter and/or insertion of ureteral stent..... add			33.54		
97080	With retrograde pyelogram..... add			20.68		
97088	With needle biopsy of prostate..... add			43.91		
<b>Therapeutic Procedures</b>						
(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 1-2 cm. diameter..... add			107.32		
97098	- single tumour over 2 cm. diameter..... add			216.32		
97100	- multiple tumours..... add			216.32		
97102	With resection bladder neck - female..... add			134.35		
97104	- male..... add			350.88	1	1
97106	With electro-surgical ureteral meatotomy..... add			134.35		
97108	With removal of foreign body or calculus..... add			134.35		
<b>Introduction (IOP)</b>						
Catheterization						
97120	- office.....	5.89		6.54		
97122	- home.....	8.34		9.27		
	- hospital.....	VF		VF		
97126	Intravesicular chemotherapy.....	9.81		10.90		
<b>Incision</b>						
97130	Aspiration (IOP).....			13.08		
97132	Cystotomy with trochar or cannula and insertion of tube...	57.88		64.31	5	5
97136	Incisional cystotomy or cystostomy.....		40.85	135.16	5	5
97138	Incisional cystotomy or cystostomy and electrocoagulation of tumour.....		40.85	194.02	5	5
97140	Cystolithotomy.....		40.85	162.40	5	5
97142	Cutaneous vesicostomy.....		40.85	231.08	5	5
97144	Reduction cystoplasty (bladder plication).....		40.85	189.66	5	5

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE UROGENITAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>BLADDER (Cont'd)</b>						
<b>Excision</b>						
Cystectomy						
97150	Partial for tumour or diverticulum (single or multiple) .....		49.02	249.50	6	6
97152	- with reimplantation of ureter .....		49.02	322.64	7	7
97154	- with reimplantation of ureters .....		49.02	354.25	7	7
97156	Complete cystectomy, without transplant.....		49.02	259.42	10	10
97160	- with uretero-ileal conduit .....		65.36	1050.00	15	15
97162	Complete cystectomy with Koch pouch urinary diversion ..		73.53	1432.45	15	15
97164	Excision of urachal cyst or sinus with or without umbilical hernia repair .....		49.02	155.87	6	6
97166	Excision of urachus, repair of bladder and diversion of urine .....		49.02	161.32	6	6
Extrophy						
97168	- excision of bladder and repair of abdominal wall, inclusive of graft .....		49.02	113.36	6	6
97174	- plastic repair of extrophy using bladder and including skin flaps .....		49.02	388.04	6	6
<b>Repair</b>						
97228	Urinary diversion procedure using intestine, without cystectomy .....		73.53	983.75	15	15
97230	Repair of ruptured bladder .....		40.85	194.02	6	6
97232	Cystoplasty, using intestine .....		40.85	388.04	9	9
97234	Suprapubic sphincterectomy for Marion's disease.....		40.85	194.02	5	5
Plastic repair of bladder neck						
97236	- child.....		40.85	194.02	5	5
97238	- adult or adolescent.....		40.85	259.42	5	5
97240	- with diverticulectomy .....		40.85	316.10	7	7
<b>Destruction</b>						
97250	Litholapaxy, visual or tactile and removal of fragments.....		40.85	128.62	4	4
<b>Suture</b>						
Closure of fistula						
97260	External, suprapubic .....		32.68	161.32	4	4
97262	Vesico-vaginal - vaginal approach.....		32.68	234.35	6	6
97264	- trans-vesical approach .....		40.85	250.70	6	6
97266	Vesico-rectal or vesicosigmoid .....		40.85	239.80	6	6

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE UROGENITAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>URETHRA</b>						
<b>Incision</b>						
97280	Biopsy of urethra without endoscopy (IOP) .....			13.08	4	4
97282	Urethrotomy, external .....	24.51		128.62	4	4
97288	Urethrostomy .....	24.51		128.62	4	4
97290	Meatotomy and plastic repair .....			29.43	4	4
97296	Peri-urethral abscess - complete care.....			32.70	4	4
<b>Excision</b>						
97300	Caruncle.....	24.51		65.40	4	4
97302	Urethral papilloma, single or multiple .....			65.40	4	4
	Stricture, including diversion					
97304	- 1 stage .....	24.51		226.72	4	4
97306	- 2 stage - first stage.....	24.51		128.62	4	4
97308	- second stage.....	24.51		194.02	4	4
97310	Diverticulectomy - male or female .....			161.32	4	4
97312	Posterior urethral valve .....	32.68		161.32	4	4
97314	Prolapse urethra, excision.....			59.95	4	4
97316	Urethrectomy - radical .....	32.68		113.36	4	4
<b>Endoscopy</b>						
97320	Urethroscopy - diagnostic (IOP) .....			19.62	4	4
97322	- with biopsy (IOP).....			45.78	4	4
97324	Internal urethrotomy .....			64.31	4	4
97326	Removal of foreign body or calculus .....			98.10	4	4
<b>Repair</b>						
97330	Urethral sling .....	24.51		<b>282.04</b>	4	4
97332	Marshall Marchetti .....	40.85		293.82	5	5
97334	Insertion of artificial urinary sphincter .....	32.68		714.60	6	6
	Urethroplasty - 1 <sup>st</sup> stage					
97336	- posterior .....	32.68		200.56	6	6
97338	- anterior .....	32.68		151.51	4	4
97340	- 2 <sup>nd</sup> stage .....	32.68		120.99	4	4
97342	One stage repair (to include skin graft if necessary) .....	32.68		200.56	6	6
97344	Kauffman type procedures for urinary incontinence .....	24.51		200.56	5	5
97346	- where perineum has been previously operated on for incontinence.....	24.51		231.08	5	5
97348	- removal of perineal incontinence prosthesis.....	24.51		75.21	5	5
<b>Suture</b>						
97360	Rupture, anterior urethra (diversion of urine, extra).....	32.68		97.01	4	4
97362	Posterior urethra - immediate repair .....	32.68		257.24	4	4
97364	- late repair .....	32.68		322.64	5	5
<b>Fistula</b>						
97366	- penile urethra (diversion of urine, extra) .....			64.31	4	4
97368	- perineal urethra.....	32.68		194.02	4	4
97370	- recto-urethral with diversion, colostomy and closure of colostomy.....	49.02		322.64	7	7

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE UROGENITAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>URETHRA (Cont'd)</b>						
<b>Destruction</b>						
97380	Urethro-vesicolysis .....		24.51	128.62	4	4
97382	Transurethral incision or resection of external sphincter (when sole operative procedure) .....			174.40	4	4
<b>Manipulation (IOP)</b>						
Dilation of stricture, male						
97390	- local anaesthetic.....	12.75		14.17		
97392	- general anaesthetic.....			32.70	4	4
97394	Dilation of urethra, female.....	5.89		6.54		
97396	- general anaesthetic.....			21.80	4	4



**SURGICAL PROCEDURES**  
**OPERATIONS ON THE DIGESTIVE SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>MOUTH</b>						
<b>Incision</b>						
95450	Drainage of Ludwig's Angina, complete care.....			70.85	5	5
95452	Biopsy (IOP) .....			33.75	4	4
<b>Excision</b>						
95460	Simple excision of lesion (IOP) .....		32.68	67.55	4	4
95462	Excision of ranula .....		32.68	157.80	4	4
95464	Composite resection of lesion of oral cavity and/or oropharynx with partial resection of mandible .....		81.70	695.95	12	12
95466	Extended composite resection of lesion of oral cavity and oropharynx with partial resection of mandible and resection of maxilla.....		81.70	775.60	12	12
95468	Excision of intra-oral tumour (greater than 2.0 cm. average diameter) .....		32.68	325.80	6	6
95470	Oro-pharyngeal carcinoma - excision floor of mouth, mandible and glands of neck Cryosurgery or treatment of premalignant or malignant lesion(s) of oral cavity or sinuses		65.36	490.50	12	12
95474	- minor .....			52.32	4	4
95478	- intermediate .....			132.98	4	4
95482	- major - initial .....			185.30	6	6
95484	- repeat within 30 days .....			92.65	6	6
<b>LIPS</b>						
<b>Incision</b>						
95490	Biopsy (IOP) .....			33.70	4	4
<b>Excision</b>						
95500	Wedge resection of lip vermillion .....		24.51	96.14	4	4
95502	Resection of lip with plastic repair.....		32.68	227.45	4	4
95504	Excision of lesion (IOP).....	81.42	32.68	90.47	4	4
95506	Lip shave (Leukoplakia).....		32.68	180.70	4	4
<b>Reconstruction</b>						
95510	Cleft lip - unilateral .....		65.36	325.40	8	8
95512	Reconstruction with lip switch flap .....		65.36	398.20	8	8
95514	Complex reconstruction or revision of previous repair and excision .....		IC	IC	IC	IC

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE DIGESTIVE SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>TONGUE</b>						
<b>Incision (IOP)</b>						
95520	Biopsy .....	30.38		33.75	4	4
	Tongue tie, release of					
95524	- local anaesthetic .....	43.60		48.45		
95526	- general anaesthetic .....			48.45	4	4
<b>Excision</b>						
	Glossectomy					
95530	- partial .....		65.36	187.95	8	8
95532	- complete .....		65.36	268.30	8	8
95534	Wedge resection of lesion (IOP) .....			58.35	4	4
<b>Repair</b>						
95540	Glossoplasty .....		32.68	187.95	4	4
<b>Suture</b>						
95550	Extensive laceration .....		32.68	IC	4	4
<b>TEETH AND GUMS</b>						
<b>Incision</b>						
95560	Drainage of alveolar abscess, general anaesthetic (IOP) .			48.45	4	4
<b>Excision</b>						
	Extraction of tooth (complete care)					
95564	- single .....			30.00	4	4
95566	- each additional tooth..... add			15.00		
<b>PALATE AND UVULA</b>						
<b>Incision</b>						
95570	Palate abscess (IOP) .....			21.80	4	4
95572	Fenestration of palate for radiotherapy.....				4	4
95574	Biopsy of palate (IOP) .....			33.75	4	4
<b>Excision</b>						
95580	Uvulectomy or biopsy of local lesion (IOP).....			33.75	4	4
<b>Repair</b>						
95590	Cleft palate .....		65.36	329.70	8	8
95592	Removal of sutures .....			35.40	4	4
95594	Bone graft to palate .....		49.02	299.70	8	8
<b>Closure of fistula</b>						
95600	- anterior alveolar .....		32.68	176.40	4	4
95602	- palate .....		49.02	251.30	6	6

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE DIGESTIVE SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>SALIVARY GLANDS AND DUCTS</b>						
<b>Incision</b>						
	Sialolithotomy					
95610	- simple .....		32.68	37.06	4	4
95612	- complicated .....		32.68	98.60	4	4
95614	Biopsy (IOP) .....		32.68	32.70	4	4
<b>Excision</b>						
95620	Submaxillary gland .....		32.68	273.80	4	4
	Parotid gland					
95622	- total - with preservation of facial nerve.....		32.68	<b>690.90</b>	8	8
95624	- without preservation of facial nerve.....		32.68	<b>593.00</b>	8	8
95626	- subtotal - with preservation of facial nerve .....		32.68	<b>642.35</b>	7	7
95630	- without preservation of facial nerve .....		32.68	<b>395.45</b>	6	6
95634	Excision small tumour .....		32.68	<b>51.23</b>	4	4
<b>Repair</b>						
95640	Plastic repair of duct .....		32.68	192.50	4	4
95642	Dilation of duct (IOP).....	26.24		29.15	4	4
<b>Probing</b>						
95650	Duct (IOP).....			7.09		
<b>PHARYNX, ADENOIDS AND TONSILS</b>						
<b>Incision</b>						
95660	Drainage of retropharyngeal, intra-oral or peritonsillar abscess (IOP).....			48.45	4	4
95662	Drainage of lateral pharyngeal abscess.....		32.68	145.95	4	4
95668	Biopsy of pharynx (IOP).....			33.75	4	4
<b>Excision</b>						
	Branchial					
95670	- cyst.....		32.68	292.00	4	4
95672	- sinus.....		32.68	292.00	4	4
95674	- fistula.....		32.68	292.00	4	4
95676	Thyroglossal duct, cyst, sinus or fistula.....		32.68	292.00	4	4
95678	- recurrent procedure.....		32.68	390.55	4	4
	Tonsillectomy, includes adenoidectomy					
95680	- child under 16.....			148.53	4	4
95682	- adolescent or adult.....			152.65	4	4
95684	Adenoidectomy only - child or adult .....			80.30	4	4
95686	Secondary suture following T and A .....			56.60	4	4
95688	Excision of parapharyngeal space lesions with mobilization of parotid gland.....		32.68	583.05	8	8
95690	Pharyngectomy - trans-hyoid or lateral .....		65.36	752.75	11	11
95692	Pharyngo-laryngectomy .....		65.36	845.85	14	14
<b>Repair</b>						
95696	Pharyngoplasty .....		65.36	343.05	8	8

## SURGICAL PROCEDURES

## OPERATIONS ON THE DIGESTIVE SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>OESOPHAGUS</b>						
For procedures on the oesophagus the following basic fees for Anaesthesiologists and Assistants will apply <u>except</u> for endoscopies.						
95700	- cervical approach.....		49.02		7	7
95702	- thoracic approach .....		106.21		13	13
95704	- abdominal approach .....		57.19		8	8
<b>Endoscopies with or without biopsies (IOP)</b>						
95710	Oesophagoscopy .....	64.84		72.04	4	4
95712	- with removal of foreign body .....			36.20		
	- with injection of varices					
95714	- initial.....			38.60		
95716	- subsequent .....			38.60		
95718	- with dilation .....			32.70		
95720	- with bronchoscopy .....			59.59	2	2
95722	- with gastroscopy and gastric photography, same intubation .....			41.58		
95724	- with gastroscopy and gastric photography, separate intubation .....			52.32		
95726	- with gastroscopy with or without duodenoscopy ..	34.30		38.11	2	2
95728	- with gastroduodenoscopy with cannulation of pancreatic and/or common bile duct .....			242.76	2	2
<b>95730</b>	<b>- management of uncomplicated upper gastrointestinal bleeding, by any technique....add</b>			<b>46.30</b>		
<b>95732</b>	<b>- management of complicated upper gastrointestinal bleeding by any technique in haemodynamically unstable patients with active bleeding during endoscopy.....add</b>			<b>69.70</b>		
<b>Incision</b>						
Oesophagostomy						
95750	- cervical - other than neonatal.....			154.45		
95752	- neonatal .....			213.64		
95754	- thoracic .....			213.64		
<b>Excision</b>						
95770	Intrathoracic diverticulum .....			283.40		
95772	Crico pharyngeal diverticulum .....			371.20		
95776	Partial oesophageal resection and reconstruction (including intestinal transposition) .....			1030.36	17	17
95778	Resection of oesophagus.....			607.14		
95780	Total resection of oesophagus .....			932.54	17	17
95781	- with reconstruction.....			561.49		
95782	Oesophago-gastrectomy .....			1123.09		
<b>Repair</b>						
95794	Oesophagoplasty .....			330.89		
95796	Heller procedure.....			617.25		
Oesophageal hiatus hernia						
95798	- abdominal or transthoracic approach with fundoplication .....			571.53		
95802	- recurrent .....			736.97		
95804	- with oesophagoplasty .....			110.38		
95806	Ruptured oesophagus .....			526.46		

## SURGICAL PROCEDURES

## OPERATIONS ON THE DIGESTIVE SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>OESOPHAGUS (Cont'd)</b>						
95808	Oesophago-gastrostomy.....			426.23		
95810	Oesophageal bypass, cervical.....			559.96		
95812	Oesophageal stricture (Thal) - may include oesophageal hiatus hernia repair with or without gastroplasty, cervical.....			389.97		
<b>Suture</b>						
95820	Closure of oesophago-tracheal fistula.....			625.56		
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.....			35.97		
95842	- retrograde dilatation.....			14.17		
<b>STOMACH</b>						
<b>Endoscopies (IOP)</b>						
95850	Gastroscopy (with or without biopsy or photography).....	90.89		100.99	4	4
95856	Gastroscopy, removal of foreign body.....			92.05	4	4
95858	- subsequent (within 3 months following previous gastroscopy).....			41.58	4	4
95860	Endoscopic removal of gastric polyp.....			41.58	4	4
<b>Incision</b>						
Gastrotomy						
95870	- with removal of tumour or foreign body.....		57.19	211.26	7	7
95872	- with suture of bleeding peptic ulcer.....		57.19	387.55	9	9
95874	Pyloromyotomy (Ramstedt's).....		81.70	452.14	10	10
95876	Gastrostomy.....		57.19	291.53	7	7
95878	Full thickness revision gastrostomy.....		49.02	228.84	6	6
<b>Excision</b>						
Biopsy (IOP)						
95890	- by gastroscopy.....			84.62	4	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.....		57.19	398.30	7	7
95906	- partial or subtotal, with or without vagotomy.....		57.19	645.93	8	8
95914	- plus cholecystectomy at same time.....		57.19	507.57	8	8
95916	- plus repair of hiatus hernia.....		57.19	507.57	8	8
95918	- after previous gastroenterostomy.....		57.19	515.42	8	8
95920	- after previous partial gastrectomy.....		57.19	534.51	8	8
95922	- total gastrectomy.....		57.19	837.30	9	9
95932	Excision of gastroduodenal lesion, recurrent ulcer.....		57.19	498.89	8	8
95934	Excision of gastrojejunal lesion, recurrent ulcer.....		57.19	498.89	8	8
95936	Vagotomy.....		57.19	387.55	7	7
<b>Bariatric Surgery</b>						
95938	Gastric bypass for morbid obesity.....		57.19	1000.00	10	10
95940	Sleeve Gastrectomy.....		57.19	1000.00	10	10
95942	Adjustable gastric banding.....		57.19	1000.00	10	10

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE DIGESTIVE SYSTEM**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>STOMACH (Cont'd)</b>					
<b>Repair</b>					
95950					
		57.19	387.55	7	7
95952					
		57.19	516.73	7	7
95956					
		57.19	387.55	7	7
95962					
		57.19	332.16	7	7
95964					
		57.19	460.70	7	7
95966					
		57.19	468.73	8	8
<b>Suture</b>					
95980					
		40.85	186.81	6	6
95982					
		57.19	387.55	7	7
95984					
		57.19	373.62	7	7
<b>INTESTINES (EXCEPT RECTUM)</b>					
<b>Endoscopy, includes dilation for access (IOP)</b>					
96000					
			109.00	4	4
96004					
			137.34	4	4
<b>96006</b>			<b>185.14</b>		
<b>Small bowel push enteroscopy.....</b>					
<b>Colonoscopy using flexible scope</b>					
96030					
	46.94		52.16	4	4
96032					
			51.75		
96034					
			37.11		
96036					
			29.69		
96038					
			27.24		
96040					
			18.61		
<b>96041</b>					
			<b>46.30</b>		
<b>96042</b>					
			<b>54.25</b>		
<b>96044</b>					
			<b>107.50</b>		
96046					
			42.10		
96048					
			21.50		
96050					
			133.10	4	4
96052					
			68.70		
<b>Incision</b>					
<b>Enterotomy</b>					
96060					
		49.02	387.55	7	7
<b>Small intestine</b>					
96062					
		49.02	387.55	7	7
96064					
		49.02	376.77	7	7
96066					
			50.90		
<b>Large intestine</b>					
96068					
		49.02	249.44	7	7
96070					
		49.02	221.84	7	7
96072					
		49.02	228.84	6	6
96074					
		49.02	478.45	6	6
96076					
		49.02	178.17	6	6

## SURGICAL PROCEDURES

## OPERATIONS ON THE DIGESTIVE SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>INTESTINES (EXCEPT RECTUM) (Cont'd)</b>						
96078	Revision of stenosis or obstruction more than 4 weeks after original operation.....		49.02	82.73	6	6
96080	Entero-enterostomy .....		49.02	387.55	7	7
<b>Excision</b>						
96090	Biopsy by intubation (IOP) .....			84.68	4	4
96092	Local excision of lesion of intestine.....		49.02	241.81	7	7
96094	Resection of exteriorized intestine .....		49.02	165.44	6	6
Enterectomy with anastomosis						
Small intestine						
96096	- duodenum .....		49.02	526.13	7	7
96098	- other .....		49.02	516.73	7	7
Small and large intestine						
96100	- terminal ileum, caecum and ascending colon.....		49.02	645.91	7	7
96102	Large intestine - any portion .....		49.02	645.91	7	7
96106	Ileostomy, subtotal colectomy.....		49.02	645.91	7	7
96108	Total colectomy with ileorectal anastomosis .....		65.36	860.50	9	9
96112	Ileostomy plus total colectomy plus abdomino-perineal resection.....		65.36	1184.18	10	10
96114	- 2 stage procedure - (1 <sup>st</sup> stage) .....		65.36	664.33	10	10
96116	- (2 <sup>nd</sup> stage).....				6	6
96118	- 2 surgeon team - abdominal.....		65.36	432.70	10	10
96120	- perineal .....		65.36	203.63		
<b>Intestinal Obstruction</b>						
96130	Without resection - adult.....		49.02	538.26	6	6
96132	- child.....		49.02	476.15	6	6
96134	With entero-enterostomy.....		49.02	538.26	7	7
96136	With resection .....		49.02	645.91	7	7
96140	Intestinal atresia (newborn).....		49.02	380.63	7	7
96142	Meconium ileus.....		49.02	414.88	7	7
<b>Repair</b>						
96150	Faecal fistula, radical with resection .....		49.02	380.63	7	7
Revision of ileostomy or colostomy						
96152	- skin level .....		40.85	85.46	5	5
96154	- full thickness.....		49.02	249.44	6	6
96162	Caecopexy or sigmoidopexy, independent operation .....		49.02	151.78	6	6
96164	Formation of an ileal pouch and primary anastomosis following total colectomy.....			1549.49	7	7
<b>Suture</b>						
96170	Suture of intestine .....		49.02	301.50	6	6
96172	Suture of intestine with choledocotomy.....		49.02	241.76	7	7
Closure of colostomy or enterostomy						
96174	- with resection .....		49.02	406.85	7	7
96176	- without resection .....		40.85	406.85	7	7
96178	Plication of small intestine for adhesions .....		49.02	376.71	7	7
<b>Manipulation (IOP)</b>						
96190	Reduction of prolapse .....			16.35	4	4
96192	Dilation of enterostomy, colostomy, etc. ....			16.63	4	4
96196	Intubation of small intestine .....	39.62		44.03	4	4

## SURGICAL PROCEDURES

## OPERATIONS ON THE DIGESTIVE SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>MECKEL'S DIVERTICULUM AND THE MESENTERY</b>						
<b>Excision</b>						
96200	Meckel's diverticulum .....		40.85	376.78	6	6
96204	Local excision of lesion .....		40.85	165.44	6	6
96206	Resection of mesentery.....		40.85	211.26	6	6
96208	Biopsy through laparotomy.....		40.85	165.44	6	6
<b>APPENDIX</b>						
<b>Incision</b>						
96220	Drainage of abscess, complete care .....		40.85	165.44	6	6
<b>Excision</b>						
96230	Appendectomy .....		40.85	351.74	6	6
96232	- with gross perforation and peritonitis .....		40.85	376.77	6	6
<b>RECTUM</b>						
<b>Endoscopy, includes dilation for access (IOP)</b>						
96240	Sigmoidoscopy - rigid scope .....	20.60		22.89	4	4
96242	- with biopsy.....	25.51		28.34	4	4
96244	- with anoscopy (separate instrumentation) .....	26.73		29.70	4	4
<b>Incision</b>						
Proctotomy						
96250	- with exploration.....		32.68	77.06	4	4
96252	- with decompression (imperforate anus).....		32.68	77.06	4	4
96254	- with drainage (perirectal abscess) .....		32.68	71.94	4	4
<b>Excision</b>						
Proctectomy						
96260	- anterior resection.....		49.02	753.57	8	8
96262	Abdomino-perineal resection or pull through					
	- 1 surgeon.....		65.36	968.87	10	10
	- 2 surgeon team					
96264	- abdominal surgeon.....		65.36	432.70	10	10
96266	- perineal surgeon .....			203.63		
96268	Hartmann procedure .....		49.02	592.08	9	9
96272	Proctosigmoidectomy for prolapse .....		49.02	414.88	9	9
96274	Biopsy of rectosigmoid for Hirschsprung's disease (IOP)..		24.51	38.18	4	4
96278	Presacral or transsacral proctotomy and excision of lesion		32.68	249.44	6	6
Polyps or tumours of rectum or sigmoid (max. 2 polyps any size or technique) (IOP)						
96280	- electrocoagulation - base under 2 cm. ....			15.27	4	4
96282	- excision - base under 2 cm. ....		24.51	53.45	4	4
96284	- electrocoagulation or excision - base over 2 cm. ....		24.51	96.73	4	4



**SURGICAL PROCEDURES**  
**OPERATIONS ON THE DIGESTIVE SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>RECTUM (Cont'd)</b>						
<b>Repair</b>						
96290	Anastomosis of rectum .....		32.68	428.47	6	6
96292	Proctostomy .....		32.68	211.26	4	4
<b>Rectal prolapse</b>						
96300	Excision of mucous membranes .....		24.51	139.99	4	4
96302	Perineal repair, major.....		32.68	387.55	4	4
96304	Abdominal approach.....		49.02	538.26	8	8
96306	Insertion of Thiersh wire.....		24.51	150.18	4	4
<b>Suture</b>						
Suture of rectum, trauma						
96310	- external approach.....		32.68	155.38	4	4
96312	- intraperitoneal approach.....		49.02	249.44	6	6
Closure of fistula						
96314	- recto vaginal (any repair).....		32.68	430.61	6	6
96316	- recto vesical .....		32.68	268.54	6	6
<b>Manipulation (IOP)</b>						
96320	Dilation and/or disimpaction under general anaesthesia (sole procedure) .....			28.00	4	4
96322	Fecal disimpaction - no anaesthetic.....	16.68		18.53		
96324	Removal of foreign body .....		IC	IC	IC	IC
<b>OPERATIONS ON THE ANUS</b>						
<b>Endoscopy, includes dilation for access</b>						
96330	Proctoscopy (IOP) .....	6.38		7.09		
<b>Incision</b>						
96340	Biopsy (IOP) .....			23.35	4	4
96342	Thrombosed haemorrhoid (IOP) .....	13.25		14.72	4	4
96344	Sphincterotomy.....		24.51	170.84	4	4
96346	- with repair of fissure .....		24.51	309.63	4	4
<b>Excision</b>						
96350	Local excision of lesion, e.g., fissure.....	70.57	24.51	78.41	4	4
96352	Haemorrhoidectomy, with or without sigmoidoscopy or repair of fissure.....		24.51	309.63	4	4
96354	Complete haemorrhoidectomy using cryotherapy and/or Barron ligation(s) including rectal dilation (IOP) .....	51.53		57.26		
96356	Barron non-operative haemorrhoidectomy (IOP) .....	16.04		17.81		
96360	Local excision for malignancy .....		24.51	124.72	4	4
96364	Anal polyp, haemorrhoidal tags .....	35.29	24.51	39.21	4	4
96366	Fistula-in-ano .....		24.51	309.63	4	4
96368	Perineal pull through for imperforate anus .....		24.51	124.72	4	4
<b>Introduction</b>						
96380	Haemorrhoid injections, max. of 4 in any one year .....			15.45		
96382	Injections for pruritus ani or fissure .....			23.35	4	4

## SURGICAL PROCEDURES

## OPERATIONS ON THE DIGESTIVE SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>OPERATIONS ON THE ANUS (Cont'd)</b>						
<b>Repair</b>						
96396	Excision of scar for stenosis.....		24.51	91.07	4	4
96398	Anoplasty, for stenosis .....		32.68	193.82	4	4
96400	Repair of anal sphincter .....		32.68	180.94	4	4
96402	Repair of anal sphincter and ano-rectal ring.....		32.68	249.44		
<b>Destruction (IOP)</b>						
96410	Curettage of fissure or fistula .....	29.78		33.09	4	4
96412	Cauterization of fissure.....	23.31		25.90	4	4
96416	Fulguration of condylomata .....	38.38		42.64	4	4
<b>Manipulation</b>						
96420	Dilation of anal sphincter (IOP) .....	6.38		7.09	4	4
<b>LIVER</b>						
<b>Incision</b>						
96430	Biopsy - incisional (IOP).....			42.00		
96432	- needle (IOP).....			59.68	4	4
96434	Hepatotomy .....		57.19	249.44	7	7
<b>Excision</b>						
Hepatectomy						
96436	- local excision of lesion .....		57.19	429.54	7	7
96438	- lobectomy (includes cholecystectomy) .....		98.04	1022.69	8	8
<b>Formal Anatomical Resection</b>						
96442	- one or two liver segments .....			1184.60	12	12
96444	- three or four liver segments .....			1652.15	12	12
96448	- five or more liver segments .....			1784.60	12	12
<b>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.</b>						
96450	Laparotomy, cholangiogram and biopsy (neonatal jaundice) .....		49.02	228.52	6	6
Liver transplant						
96452	- donor .....		IC	IC	16	16
96454	- recipient .....		IC	IC	IC	IC
<b>Repair</b>						
96460	Marsupialization of cyst or abscess.....		57.19	249.44	7	7
<b>Suture</b>						
96470	Rupture or wound.....		65.36	249.44	8	8
<b>BILIARY TRACT</b>						
<b>Endoscopy, to include examination of stomach and duodenum (IOP)</b>						
96480	Manipulation and/or removal of common bile duct stones with or without sphincterotomy.....			482.40	5	5
96482	Subsequent procedure (within 3 months of previous endoscopic procedure) .....			76.30	5	5

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE DIGESTIVE SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>BILIARY TRACT (Cont'd)</b>						
<b>Incision</b>						
96504	Biliary duct calculus manipulation and/or removal via T-tube tract - when sole procedure performed (IOP) .....			52.54	7	7
96508	Cholecystostomy .....	57.19		216.35	7	7
96510	Choledochotomy .....	57.19		333.43	7	7
96514	Transduodenal sphincterotomy and choledochotomy (previous cholecystectomy) .....	57.19		509.06	9	9
96516	Choledochoduodenostomy .....	57.19		516.73	9	9
96518	Cholecystogastrostomy.....	57.19		273.29	7	7
96520	Cholecystoenterostomy .....	57.19		334.35	7	7
96524	Hepatic choledochenterostomy.....	57.19		705.42	9	9
<b>Excision</b>						
96530	Cholecystectomy with or without cholangiogram .....	57.19		482.17	7	7
96532	Cholecystectomy and choledochotomy.....	57.19		592.08	8	8
96534	Cholecystectomy, choledochotomy and transduodenal sphincterotomy .....	57.19		711.94	9	9
96536	Cholecystectomy and hiatus herniorraphy .....	57.19		657.46	7	7
96542	Choledochectomy .....	57.19		414.88	8	8
<b>Repair</b>						
96550	Common duct stricture.....	57.19		498.89	10	10
<b>PANCREAS</b>						
<b>Incision</b>						
96560	Biopsy - needle (IOP).....			52.18		
96562	- incisional (IOP) .....			76.36	7	7
96564	Pancreatotomy.....	57.19		228.84	7	7
<b>Excision</b>						
Pancreatectomy						
96570	- complete.....	57.19		1270.20	11	11
96572	- partial resection of head .....	57.19		1005.00	11	11
96574	- "Whipple Type" operation .....	57.19		1785.45	15	15
96576	- local excision of lesion.....	57.19		483.06	8	8
96578	- islet cell tumour .....	57.19		411.00	8	8
96582	Resection of entire body and tail of pancreas, spleen .....	73.53		986.05	11	11
96584	Excision pancreatic cyst.....	57.19		337.95	7	7
96586	Biopsy of other retroperitoneal lesion (IOP).....			76.36	7	7
<b>Repair</b>						
96590	Pancreatic - cystogastrostomy .....	57.19		430.61	8	8
96594	- cystojejunostomy.....	57.19		333.43	8	8
96596	Marsupialization of cyst.....	57.19		249.44	8	8
96598	Anastomosis of body and tail of pancreas to intestine (Puestow operation) .....	73.53		450.61	10	10

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE DIGESTIVE SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>ABDOMEN, PERITONEUM AND OMENTUM</b>						
<b>General</b>						
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		
<b>Paracentesis (IOP)</b>						
96620	Aspiration for diagnostic sample .....	17.25		19.17		
96622	Aspiration with therapeutic drainage with or without diagnostic sample .....	35.66		39.62	4	4
96626	Paracentesis with lavage for diagnosis .....			50.71	4	4
<b>Incision</b>						
96630	Biopsy of omentum (single or multiple) (IOP) .....			27.25		
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	4
96636	Laparotomy (biopsy extra) .....		49.02	280.70	6	6
96642	Laparotomy for acute trauma .....		49.02	365.40	6	6
96644	- with repair of intestine, single..... add			131.00	3	3
96646	- multiple or with resection .....			194.30	3	3
96648	- with splenectomy .....	16.34		262.00	3	3
96650	- with repair of lacerated liver .....	16.34		172.90	3	3
96652	- with repair of diaphragm .....	16.34		112.30	2	2
<b>Peritoneal abscess</b>						
96660	- subphrenic .....		57.19	197.22	7	7
96662	- abdominal .....		49.02	154.45	6	6
96664	Pelvic abscess, incision drainage - rectal or vaginal approach (IOP) .....			64.31	4	4
96670	Removal of infected sutures from abdominal wall - general anaesthetic (IOP) .....			57.26	4	4
96672	Umbilical vein intraabdominal dissection and catheterization .....		49.02	134.27	6	6
<b>Insertion of peritoneo - jugular shunt for ascites</b>						
96676	- primary .....		57.19	185.80	7	7
96678	- revision within 30 days .....		57.19	113.25	7	7
<b>Excision</b>						
96690	Desmoid tumour, depending on extent .....		32.68	IC	6	6
96694	Umbilectomy - plastic .....		32.68	78.41	4	4
96700	Panniculectomy .....		32.68	428.48	6	6
96701	- with repair of umbilical hernia .....			120.01		
96702	Mesenteric cyst .....		49.02	197.22	6	6
<b>Endoscopy</b>						
<b>Peritoneoscopy or laparoscopy (IOP)</b>						
96710	- without biopsy .....			144.00	6	6
96712	- with biopsy and/or lysis of adhesions and/or removal of foreign body and/or cautery of endometrial implants .....			161.16	6	6
96714	Laser treatment of extensive pelvic disease (includes laparoscopy) .....			211.55	6	6

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE DIGESTIVE SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>ABDOMEN, PERITONEUM AND OMENTUM</b>						
<b>(Cont'd)</b>						
<b>Repair</b>						
96720	Omentopexy, as independent operation .....		49.02	130.80	6	6
	Herniotomy					
96722	- Inguinal or femoral - single .....		32.68	281.62	4	4
96728	- with hydrocele .....		32.68	354.18	4	4
96730	- Unilateral with exploration of other side - infants and children .....		32.68	300.00	4	4
	- Strangulated or incarcerated					
96732	- without resection of bowel .....		49.02	344.49	4	4
96734	- with resection of bowel .....		49.02	598.07	7	7
96736	- Inguinal and femoral - same side .....		32.68	352.03	4	4
	- Umbilical					
96738	- adolescent or adult .....		32.68	301.50	4	4
96740	- child (operative) .....		32.68	165.44	4	4
	Omphalocele and gastrochisis					
96748	- 1 stage repair .....		57.19	249.44	7	7
	- multiple staged repair					
96750	- gross method of silon mesh .....		57.19	249.44	7	7
96752	- second stage repair (completion of abdominal wall closure) .....		57.19	253.79	7	7
	Diaphragmatic, other than oesophageal hernia - 1 stage procedure					
96754	- trans-abdominal .....		73.53	330.89	9	9
96756	- trans-thoracic .....		106.21	330.89	13	13
96760	Ventral .....		49.02	401.12	6	6
96762	Massive incisional hernia .....		49.02	452.14	6	6
96766	Recurrent - all types, excepting diaphragmatic .....		49.02	429.67	6	6
96770	Epigastric .....		32.68	284.97	4	4
<b>Suture</b>						
96780	Secondary closure for evisceration .....		49.02	231.11	6	6

## SURGICAL PROCEDURES

## OPERATIONS ON THE HAEMIC AND LYMPHATIC SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>SPLEEN AND MARROW</b>						
<b>Incision (IOP)</b>						
95350	Splenic puncture and aspiration.....			43.60	4	4
	Bone marrow					
95352	- aspiration.....	36.01		40.01	4	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	4
	Bone marrow transplantation - team fee					
95360	- aspiration from donor .....		IC	IC	IC	IC
95362	- infusion into recipient.....		IC	IC	IC	IC
<b>Excision</b>						
95370	Splenectomy .....		57.19	502.50	7	7
95372	Bone button (IOP).....			35.97	4	4
<b>LYMPH CHANNELS</b>						
<b>Excision</b>						
95380	Cystic hygroma .....		49.02	231.68	6	6
<b>LYMPH NODES</b>						
<b>Incision</b>						
95400	Drainage of subfacial abscess (IOP) .....			77.23	4	4
<b>Excision</b>						
95410	Neck - local.....		49.02	111.91	6	6
95412	- limited.....		49.02	352.35	6	6
95414	- radical .....		65.36	843.27	8	8
95416	- modified radical including functional wit preservation of spinal accessory nerve.....		65.36	906.45	8	8
95418	Ilioinguinal, radical resection.....		49.02	308.91	8	8
95420	Axillary or inguinal nodes, radical resection .....		32.68	371.84	4	4
	Biopsy (IOP)					
95426	- cervical, axillary, inguinal.....		32.68	64.31	4	4
95428	- scalene.....		32.68	124.62	4	4
<b>95430</b>	<b>- sentinel node biopsy (per draining basin).....</b>		<b>49.02</b>	<b>330.45</b>	<b>6</b>	<b>6</b>
95438	Staging pelvic lymphadenectomy .....		57.19	172.22	7	7

## SURGICAL PROCEDURES

## OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>GENERAL FEES</b>						
94800	With hypothermia and without bypass, basic fee for cardiovascular procedures .....				25	25
94802	With hypothermia - extra.....			<b>172.31</b>		
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) .....			<b>391.63</b>	28	28
94805	Coronary artery repair commenced on a beating heart (extra for surgeon/basic for Anaesthesiologist) .....			<b>391.63</b>	28	28
94806	Circulatory assist device e.g., intra-aortic balloon (includes cannulation, post-operative care and supervision) (IOP).....			<b>245.94</b>	5	5
94810	Decannulation of circulatory assist device (IOP).....			<b>97.12</b>	5	5
94814	Repositioning of intra-aortic balloon pump (no claim to be made for repositioning within 24 hours of original insertion).....			<b>98.82</b>	5	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.....			<b>119.07</b>		
94820	Removal of failed vascular graft - when sole procedure (IOP).....			<b>121.14</b>	6	6
94822	Re-operation involving open heart procedures with pump (more than one month after initial operation) in addition to appropriate benefit) .....			<b>119.07</b>		
<b>HEART AND PERICARDIUM</b>						
94830	Cardiotomy with exploration.....	147.06		<b>478.14</b>	20	20
94832	- with removal of foreign body .....	147.06		<b>589.71</b>	20	20
94834	- with removal of tumour .....	147.06		<b>469.95</b>	20	20
Closure atrial septal defect						
94836	- secundum.....	147.06		<b>610.94</b>	20	20
94838	- endocardial cushion and valve defect .....	147.06		<b>1002.56</b>	20	20
94840	- with anomalous pulmonary venous drainage .....	147.06		<b>798.91</b>	28	28
94842	Closure of ventricular septal defect.....	147.06		<b>817.72</b>	28	28
94844	Total repair trilogly .....	147.06		<b>646.72</b>	28	28
94846	Total repair Tetralogy of Fallot.....	147.06		<b>934.15</b>	28	28
94848	- with previous arterial shunt.....	147.06		<b>1106.61</b>	28	28
94850	Repair total anomalous pulmonary venous drainage.....	147.06		<b>934.15</b>	28	28
94852	Total correction transposition of great vessels.....	147.06		<b>934.15</b>	28	28
94854	Pulmonary valvotomy.....	147.06		<b>560.49</b>	28	28
94856	Pulmonary valvotomy and infundibular resection.....	147.06		<b>646.72</b>	28	28
94858	Tricuspid valvotomy .....	147.06		<b>613.67</b>	20	20
94860	Tricuspid annuloplasty .....	147.06		<b>546.12</b>	20	20
94862	Tricuspid valve replacement .....	147.06		<b>715.89</b>	28	28
94864	Mitral valvotomy .....	147.06		<b>613.67</b>	20	20
94866	Mitral valvotomy - re-stenosis .....	147.06		<b>689.84</b>	20	20
94868	Mitral annuloplasty.....	147.06		<b>689.84</b>	20	20
94870	Mitral replacement .....	147.06		<b>924.24</b>	28	28
94872	Aortic valvotomy .....	147.06		<b>675.46</b>	20	20
94874	Aortic infundibular resection (ventriculomyotomy) .....	147.06		<b>776.07</b>	28	28

**SURGICAL PROCEDURES**

**OPERATIONS ON THE CARDIOVASCULAR SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>HEART AND PERICARDIUM (Cont'd)</b>						
94876	Aortic valve replacement .....		147.06	<b>1124.76</b>	28	28
94878	Aortic and mitral valvotomy - closed.....		147.06	<b>790.43</b>	20	20
94880	Aortic, mitral and tricuspid valvotomy - closed .....		147.06	<b>934.15</b>	20	20
94900	Coronary - endarterectomy .....		147.06	<b>747.32</b>	20	20
94902	- done in conjunction with coronary artery repair ... add Coronary artery repair (aortic-coronary bypass graft) (includes internal mammary)			<b>156.65</b>		
94904	- 1 .....		147.06	<b>861.58</b>	20	20
94906	- 2.....		147.06	<b>1331.53</b>	20	20
94908	- 3 or more .....		147.06	<b>1511.69</b>	20	20
	Implantation of internal mammary - sole procedure					
94910	- single .....		147.06	<b>573.43</b>	20	20
94912	- double.....		147.06	<b>704.21</b>	20	20
94914	Aspiration of pericardium (IOP) .....			<b>151.47</b>		
94916	Open biopsy of pericardium and drainage (transthoracic or epigastric) .....		147.06	<b>250.64</b>	13	13
94918	Ventricular tumor .....		147.06	<b>517.37</b>	28	28
94920	Ventricular aneurysm .....		147.06	<b>847.93</b>	28	28
94922	Aneurysm of sinus of Valsalva .....		147.06	<b>747.32</b>	28	28
	Pericardectomy					
94924	- 1 side open .....		106.21	<b>516.94</b>	20	20
94926	- both sides open or sternal split .....		106.21	<b>1018.23</b>	20	20
94940	Implantation of epicardial electrode(s) - plus implantation of pack .....		49.02	<b>511.63</b>	20	20
	Pack replacement - see fee code 54358					
94942	Replacement or repair of epicardial pacemaker lead (IOP)		24.51	<b>79.04</b>	5	5
94943	Implantation of cardioverter-defibrillator by transvenous approach.....		40.85	<b>712.54</b>	12	12
94944	Removal and/or replacement of implantable cardiovertor- defibrillator (IOP).....		24.51	<b>411.77</b>	5	5
	Ligation or division of patent ductus					
94950	- child .....		106.21	<b>430.80</b>	20	20
94952	- adolescent or adult .....		106.21	<b>717.21</b>	20	20
	Resection coarctation					
94954	- child .....		106.21	<b>560.49</b>	20	20
94956	- infant under 1 year.....		106.21	<b>646.72</b>	20	20
94958	- adolescent or adult .....		106.21	<b>790.43</b>	20	20
	Congenital heart shunt procedures					
94960	- Potts .....		106.21	<b>621.57</b>	20	20
94962	- Blalock .....		106.21	<b>556.11</b>	20	20
94964	- Glenn .....		106.21	<b>565.81</b>	20	20
94968	Creation of ASD - by balloon septostomy.....		73.53	<b>273.06</b>	9	9
94970	Orthotopic cardiac transplantation.....		IC	IC	IC	IC
94972	Donor cardiectomy .....		IC	IC	IC	IC
94974	Cardiopulmonary transplantation .....		IC	IC	IC	IC
94976	Donor heart-lung removal.....		IC	IC	IC	IC
94980	Cardiac massage - open .....		106.21	<b>184.85</b>	13	13
94984	Thoracotomy - with or without biopsy .....		106.21	<b>310.16</b>	13	13
94986	- for post-operative hemorrhage.....		106.21	<b>310.16</b>	13	13



## SURGICAL PROCEDURES

## OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>HEART AND PERICARDIUM (Cont'd)</b>						
94988	Pulmonary artery banding.....		106.21	<b>426.84</b>	20	20
94990	- with pressure studies by Anaesthesiologist, extra .....				5	5
94992	Correction of cor triatriatum .....		147.06	<b>596.42</b>	20	20
94994	Vascular ring.....		147.06	<b>610.94</b>	20	20
<b>Repair</b>						
95000	Complete A-V canal.....		147.06	<b>1006.01</b>	28	28
95002	Single ventricle .....		147.06	<b>1131.05</b>	28	28
95004	Double outlet - right/left ventricle .....		147.06	<b>1006.01</b>	28	28
95006	- ventricle with transposition.....		147.06	<b>1131.05</b>	28	28
95008	Truncus arteriosus .....		147.06	<b>1131.05</b>	28	28
95010	Interrupted aortic arch.....		147.06	<b>1006.01</b>	28	28
95012	Aorto-pulmonary window .....		147.06	<b>630.92</b>	28	28
95014	R-V outflow tract with valve and tubular graft.....		147.06	<b>704.21</b>	28	28
95016	Debanding arterioplasty of pulmonary artery .....		147.06	<b>632.35</b>	28	28
<b>ARTERIES</b>						
Cannulation for infusion chemotherapy						
95050	- superficial temporal artery.....		24.51	<b>73.65</b>	4	4
95052	- hepatic artery .....		49.02	<b>178.17</b>	6	6
95054	- carotid .....		40.85	<b>114.28</b>	5	5
95056	Regional isolation perfusion, e.g. iliac.....		81.70	<b>321.19</b>	10	10
95058	Exploration of major artery.....		49.02	194.98	IC	IC
<b>Incision</b>						
95070	Arteriotomy (IOP).....			<b>90.19</b>	4	4
<b>NOTE:</b> 95070 is <u>not</u> allowed in addition to other major cardiovascular surgery when performed at same time.						
<b>Repair - traumatic</b>						
95080	Suture of lacerated major artery or microscopic repair of digital artery.....		32.68	208.73	10	10
95082	Repair of lacerated major artery (including patch angioplasty).....		81.70	328.35	10	10
95084	- by by-pass or interposition graft .....		81.70	<b>467.08</b>	10	10
<b>Ligation</b>						
95090	Ligation of artery (as sole procedure) .....		24.51	<b>120.02</b>	8	8
95092	- internal maxillary artery (Caldwell-Luc approach).....		57.79	388.40	10	10
95094	- anterior ethmoid artery .....		49.02	285.35	6	6
95096	- internal iliac artery (uni or bilateral) .....		57.19	269.70	10	10

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE CARDIOVASCULAR SYSTEM**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>ARTERIES (Cont'd)</b>					
<b>Excision and/or Repair</b>					
<b>Preamble:</b>					
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.					
4. (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>		<u>Aortic Cross Clamp</u>		
95100	- Abdominal		- Supraceliac.....	20	20
95102			- Infracoeliac .....	17	17
95106	- Thoracic .....			25	25
95108	- Thoraco-abdominal .....			30	30
95110	Anterioplasty with or without patch graft including microvascular anastomosis, arterial and/or venous, (other than listed below).....	81.70	<b>405.96</b>	10	10
95112	Carotid - endarterectomy.....	81.70	603.48	10	10
95114	- carotid body tumour .....	81.70	<b>607.66</b>	10	10
95116	- aneurysm - reconstruction or excision with graft.	81.70	<b>647.80</b>	10	10
Aortic arch reconstruction					
95118	Innominate .....	81.70	<b>678.72</b>	10	10
95120	Subclavian .....	81.70	<b>667.09</b>	10	10
95122	Vertebral .....	81.70	<b>612.01</b>	10	10
95124	- with thoracotomy..... add	24.51	<b>119.31</b>	7	7
95126	- ruptured .....		<b>188.15</b>	3	3
Thoracic aorta aneurysm - repair or excision with graft					
95128	- ascending .....	81.70	<b>1119.39</b>	20	20
95130	- arch.....	81.70	<b>1389.88</b>	20	20
95132	- descending with or without temporary shunt.....	81.70	<b>889.02</b>	20	20
95134	- ruptured .....		<b>188.15</b>	3	3
95136	Thoraco - abdominal aneurysm.....	147.06	<b>1879.43</b>	30	30

## SURGICAL PROCEDURES

## OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>ARTERIES (Cont'd)</b>						
<b>Excision and/or Repair (Cont'd)</b>						
95138	Abdominal aorta - aneurysm.....		81.70	<b>920.52</b>	17	17
95140	- plus unilateral common femoral repair .....		81.70	<b>1003.00</b>	17	17
95142	- plus bilateral common femoral repair .....		81.70	<b>1082.51</b>	17	17
95144	- plus implantation of inferior mesenteric artery..... add			<b>136.41</b>		
95146	- ruptured..... add			<b>244.31</b>	3	3
Mesenteric or celiac artery repair						
95150	- aneurysm .....		81.70	<b>289.78</b>	10	10
95152	- excision of celiac ganglion or removal of band only ...		81.70	<b>289.78</b>	10	10
95154	- endarterectomy or graft.....		81.70	<b>667.09</b>	10	10
Aorto-iliac repair						
95156	- including common iliac repair (uni or bilateral) .....		81.70	<b>778.13</b>	17	17
95158	- plus unilateral common femoral repair .....		81.70	<b>913.33</b>	17	17
95160	- plus bilateral common femoral repair .....		81.70	<b>1010.98</b>	17	17
95162	- plus implantation of inferior mesenteric artery..... add			<b>136.41</b>		
95164	- embolectomy or thrombectomy of bifurcation (aorta or graft) .....		81.70	<b>354.82</b>	10	10
95166	Total removal of infected aortic graft (stem and limbs) (arterial reconstruction extra).....		81.70	<b>648.57</b>	17	17
95168	Closure of duodenum .....			<b>89.66</b>		
95170	Partial removal of infected aortic graft (one limb only) (arterial reconstruction extra).....		81.70	<b>264.63</b>	10	10
95172	Renal artery - aneurysm - reconstruction or excision with graft .....		81.70	<b>612.01</b>	10	10
95174	Renal artery repair .....		81.70	<b>612.01</b>	10	10
95176	Splenic artery aneurysm - reconstruction or excision with graft .....		81.70	<b>289.78</b>	10	10
95178	Iliac repair to include internal iliac aneurysm .....		81.70	<b>619.46</b>	10	10
95180	Ilio-femoral by-pass graft .....		81.70	<b>619.46</b>	10	10
Per-obturator ilio-femoral graft						
95182	- with saphenous vein.....		81.70	<b>691.61</b>	10	10
95184	- with prosthetic graft .....		81.70	<b>619.33</b>	10	10
95186	Common femoral/profunda femoris repair (profundoplasty) when sole procedure performed.....			<b>430.05</b>	10	10
95188	Extended profundoplasty .....		81.70	<b>599.93</b>	10	10
95190	Axillo-femoral, femoro-femoral or axillo-axillary graft.....		81.70	<b>592.09</b>	10	10
95192	Aorto-femoral unilateral graft (for bilateral see 95160).....		81.70	<b>667.09</b>	17	17
95194	Femoral aneurysm - reconstruction or excision with graft..		81.70	<b>461.58</b>	10	10
95196	Repair of false aneurysm at groin anastomosis .....		81.70	<b>687.15</b>	10	10
95198	Femoral-popliteal endarterectomy .....		81.70	<b>584.08</b>	10	10
Femoro-popliteal (with or without endarterectomy)						
95200	- with saphenous vein.....		81.70	<b>659.30</b>	10	10
95204	- with prosthetic graft .....		81.70	<b>573.23</b>	10	10
Femoro-anterior/posterior tibial/peroneal by-pass graft (with or without endarterectomy)						
95206	- with saphenous vein.....		81.70	<b>773.75</b>	10	10
95210	- with prosthetic graft .....		81.70	<b>686.83</b>	10	10
95212	Popliteal aneurysm .....		57.19	<b>619.46</b>	10	10
95214	Peripheral arteries other than listed - aneurysm .....		57.19	<b>315.68</b>	10	10
95216	Embolectomy - artery or graft (as sole procedure).....		57.19	<b>439.18</b>	10	10
95218	Thrombectomy - artery or graft (as sole procedure) .....		57.19	<b>441.37</b>	10	10

## SURGICAL PROCEDURES

## OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>ARTERIES (Cont'd)</b>					
<b>Excision and/or Repair (Cont'd)</b>					
95220				80.69	
					add
95222		81.70	<b>422.52</b>	10	10
					In-situ saphenous vein arterial by-pass
95224		81.70	<b>988.56</b>	17	17
95226		81.70	<b>1146.18</b>	17	17
<b>VEINS</b>					
<b>Excision</b>					
Resection of AV aneurysm or fistula with or without major graft					
95240		81.70	<b>827.23</b>	17	17
95242		81.70	<b>414.88</b>	10	10
<b>Ligation</b>					
95250			<b>40.90</b>	4	4
95252		24.51	<b>58.09</b>	4	4
95254		24.51	<b>58.09</b>	4	4
95256		40.85	<b>114.28</b>	5	5
95258		49.02	<b>303.69</b>	10	10
95260		49.02	<b>349.52</b>	10	10
95262		49.02	<b>330.89</b>	10	10
95264					High ligation and stripping of long saphenous vein with groin dissection.....
		32.68	<b>208.61</b>	4	4
95266		32.68	<b>82.66</b>	4	4
95268					Stripping of short saphenous vein with popliteal dissection
95270	<b>161.23</b>	32.68	<b>179.14</b>	4	4
					Multiple ligation and avulsion .....
95270		40.85	<b>271.99</b>	5	5
					Recurrent varicose veins - multiple ligation and/or stripping .....
95272		40.85	<b>295.99</b>	6	6
					Extra fascial and sub-fascial incompetent perforators by full fascial technique.....
95274			<b>98.43</b>		- plus stripping..... add
<b>Repair</b>					
95290					Lacerated major vein, e.g., femoral, popliteal, vena cava, axillary, subclavian, brachial or microscopic repair of digital vein.....
		32.68	231.89	4	4
95292		81.70	<b>382.42</b>	10	10
					- including patch.....
95294		81.70	<b>466.69</b>	10	10
					- by vein graft .....
95296		57.19	<b>535.62</b>	17	17
					SVC by-pass graft .....
95298		147.06	<b>611.41</b>	20	20
					Pulmonary embolectomy.....
95300		81.70	<b>343.36</b>	10	10
					Ilio-femoral thrombectomy with or without femoral vein ligation .....
95304		IC	IC	IC	IC
					Thrombectomy, other than above .....
95306		81.70	<b>889.18</b>	10	10
					Distal spleno-renal shunt.....

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE CARDIOVASCULAR SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>VEINS (Cont'd)</b>						
<b>Anastomosis</b>						
95320	Porto-caval.....		81.70	<b>648.32</b>	10	10
95326	Meso-caval .....			<b>693.54</b>	10	10
95328	Creation of AV fistula .....		32.68	<b>440.00</b>	6	6
95330	Obliteration of AV fistula .....			<b>82.55</b>	4	4
95332	Ligation or removal of by-pass graft.....			<b>82.55</b>	4	4

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE RESPIRATORY SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>NOSE</b>						
94200	EUGA of nasopharynx for malignant disease including biopsies (IOP).....			41.25	4	4
94202	EUGA of nasopharynx, if only procedure performed (IOP)			27.54	4	4
94208	Insertion of prosthesis for nasal septal perforation (IOP)...			18.30		
94210	Fibre-optic endoscopy of nasopharynx (IOP).....			27.54		
<b>Incision (IOP)</b>						
94220	Drainage of abscess or haematoma of septum - general anaesthetic.....			52.90	4	4
94222	Submucous turbinectomy .....			52.90	4	4
94224	Biopsy.....			48.45	4	4
<b>Excision</b>						
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	4
94236	- multiple (unilateral).....			56.71	4	4
94238	- single choanal polyp.....			52.90	4	4
Septum						
94260	- submucous resection including septoplasty .....			242.79	4	4
<i>All procedures connected with SMR such as nasal polypectomy, turbinectomy, ethmoidectomy, etc. - add 50% of other procedural charges.</i>						
94262	Partial septorhinoplasty (excluding osteotomies).....			475.73	7	7
94264	Complete septorhinoplasty .....			503.37	7	7
94266	- with autogenous bone graft.....			656.95	7	7
94268	bone graft autogenous.....	32.68		343.05	4	4
94270	- non-autogenous - prosthetic implant .....	32.68		220.80	4	4
94276	Septodermoplasty.....			292.00	4	4
94278	Closure of septal perforation.....			341.30	4	4
94280	Localization of cerebrospinal rhinorrhea (fluorescein injection).....			86.10	4	4
94284	Narrowing operations or implant for atrophic rhinitis - unilateral.....			241.85	4	4
94286	Excision of intranasal lesions by lateral rhinotomy approach .....		32.68	470.00	7	7
Excision of choanal atresia						
94290	- anterior nasal approach.....		32.68	343.05	4	4
94292	- puncture and insertion of tube only .....			58.86	4	4
94296	Biopsy under local anaesthetic (IOP).....			17.94		
94298	Biopsy under general anaesthetic (IOP) .....			48.45	4	4
<b>Repair</b>						
94310	Choanal atresia - dilation .....			70.25	4	4
94314	Rhinoplasty for reconstruction of cleft lip nasal deformity in adolescence or adulthood.....		32.68	354.25	7	7

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE RESPIRATORY SYSTEM**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>NOSE (Cont'd)</b>					
<b>Removal of Foreign Body (IOP)</b>					
94330					
			VF	VF	
			43.61	48.45	4 4
<b>Destruction (IOP)</b>					
94340	47.62			52.90	4 4
94342				52.90	4 4
<b>Treatment of Epistaxis (IOP)</b>					
94350	9.85			10.95	4 4
94352				VF	4 4
94356	30.38			33.75	4 4
94360		49.02		282.85	6 6
<b>ACCESSORY NASAL SINUSES</b>					
<b>Antrum or sinus lavage (IOP)</b>					
94370				5.45	
94372				41.10	
94374				41.10	4 4
<b>Sinusotomy, sinusostomy, sinusectomy as indicated</b>					
<b>Maxillary</b>					
94380		32.68		119.09	4 4
94382		32.68		235.40	4 4
94384		81.70		739.10	10 10
<b>Frontal</b>					
94388				134.24	4 4
94390				438.00	5 5
94392		32.68		438.00	6 6
94394					
		57.19		681.60	10 10
<b>Ethmoidal</b>					
94398				150.60	4 4
94400		32.68		343.05	4 4
94406				158.46	4 4
<b>Introduction</b>					
94420				11.99	4 4
<b>Suture</b>					
<b>Closure of antro-oral fistula</b>					
94430				28.34	4 4
94432				203.83	5 5
94434				232.17	5 5
<b>Repair</b>					
94436					
				822.45	15 15

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE RESPIRATORY SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>LARYNX</b>						
<b>Endoscopies (IOP)</b>						
Laryngoscopy						
Direct						
94440	- with or without biopsy .....	57.17		63.52	6	6
94442	- with removal of foreign body .....	78.48		106.45	6	6
94444	- with removal of benign growth(s) .....			148.60	6	6
94446	- with dilation of larynx and bronchoscopy .....			202.35	6	6
Indirect						
94448	- with biopsy .....	20.60		22.89	6	6
94450	- with simple removal of bone .....	10.79		11.99	6	6
94452	Using operating microscope - add to charges for laryngoscopy .....			28.34		
<b>Introduction</b>						
94456	Teflon augmentation larynx.....			163.20	6	6
<b>Excision</b>						
Laryngectomy						
94460	- total .....		49.02	838.90	13	13
94462	- partial (laryngo-fissure).....		49.02	444.85	8	8
94464	- with block dissection.....		49.02	514.48	8	8
94466	- hemilaryngectomy .....		49.02	845.85	9	9
94468	Arytenoidectomy .....		49.02	395.05	8	8
94470	Excision of benign growth(s).....		49.02	135.15	8	8
<b>Repair (including laryngoscopy)</b>						
94480	Laryngoplasty - e.g., repair of stenosis and fractures, transections (not to be billed with 94464 or 94466) .....			629.85	6	6
94482	Arytenoidopexy .....			375.95	8	8
94484	Creation of tracheo oesophageal fistula.....		24.51	187.95	4	4
94486	Insertion of voice prosthesis (IOP) .....			24.60		



## SURGICAL PROCEDURES

## OPERATIONS ON THE RESPIRATORY SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>TRACHEA AND BRONCHI</b>						
<b>Endoscopy (IOP)</b>						
Bronchoscopy						
94500	- with or without biopsy, suction or injection of contrast material			130.65	6	6
94502	- with removal of foreign body.....add			40.53	6	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 (for assessment of interstitial lung disease).....add			120.50	6	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) .....			173.25		
94526	Closure of persistent tracheostoma.....			127.45		
94528	Change of tracheostomy tube .....	9.68		10.75		
<b>Incision</b>						
Tracheostomy (IOP)						
94530	- emergency .....		40.85	181.94	5	5
94532	- elective .....		40.85	181.94	5	5
94536	Insertion of Montgomery "T" tube or similar laryngeal or tracheal stent .....		32.68	205.65	8	8
<b>Excision</b>						
94540	Segmental resection of cervical trachea.....		73.53	772.95	10	10
94542	- with resection of cricoid .....			229.00		
94546	Resection of mediastinal trachea with either sternotomy or thoracotomy .....		73.53	684.52	13	13
<b>Repair</b>						
94550	Tracheal rupture, transcervical.....		73.53	365.00	10	10

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE RESPIRATORY SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>CHEST WALL AND MEDIASTINUM</b>						
<b>Incision</b>						
94560	Excisional biopsy of rib for tumour (IOP).....		24.51	137.67	4	4
<b>Excision</b>						
94570	Chest wall tumor involving ribs or cartilage and reconstruction of chest wall .....		73.53	500.86	13	13
94578	Excision of first rib and/or cervical rib to include scalenotomy when required.....		49.02	395.02	6	6
94580	Mediastinal tumor .....		106.21	640.06	13	13
94582	Anterior mediastinotomy - sole procedure .....		24.51	191.84	6	6
<b>Endoscopies (IOP)</b>						
94590	Mediastinoscopy .....		49.02	181.38	6	6
94592	- with bronchoscopy.....		49.02	240.35	6	6
94593	- with transbronchial biopsy under image intensification (including bronchoscopy).....		49.02	271.15	6	6
94594	- with mediastinotomy.....		49.02	344.46	6	6
94596	- with bronchoscopy and mediastinotomy.....		49.02	338.55	6	6
<b>Repair</b>						
Chest Wall						
94600	- pleura - closed.....			IC	5	5
94602	- pleura - open .....			IC	13	13
94610	Pectus excavatum or carinatum repair (by reconstruction, not implant).....		49.02	668.31	11	11
<b>Surgical Collapse</b>						
Thoracoplasty						
94620	- 1 stage .....		81.70	213.64	10	10
94622	- multi-stage - each.....		73.53	141.70	9	9
Pneumolysis						
94626	- intra pleural .....		40.85	141.70	5	5
94628	- extra pleural .....		40.85	213.64	5	5
Apicolysis						
94630	- extra fascial .....		40.85	213.64	5	5
94632	- extra pleural .....		40.85	213.64	5	5
94634	Phrenicotomy (IOP) .....		40.85	59.95	5	5

## SURGICAL PROCEDURES

## OPERATIONS ON THE RESPIRATORY SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>LUNGS AND PLEURA</b>						
<b>Introduction - Thoracentesis (IOP)</b>						
Thoracic						
94660	- aspiration for diagnostic sample .....	18.23		20.26		
94662	- therapeutic drainage including sample .....	31.16		34.62	4	4
Administration of chemotherapy, including therapeutic drainage and sample						
94664	- initial .....			55.14	4	4
94666	- repeat .....			24.53	4	4
94668	Lung lavage with or without bronchoscopy for pulmonary alveolar proteinosis .....			184.94	13	13
<b>Endoscopy (IOP)</b>						
94680	Thoracoscopy or pleuroscopy with or without pleural biopsy, suction, etc. ....			201.00	5	5
94682	Transbronchial lung biopsy(s) including bronchoscopy .....			160.00	6	6
<b>Incision</b>						
94690	Biopsy of lung, needle (IOP) .....			68.14	4	4
94694	Biopsy of pleura, needle (IOP) .....			35.17	4	4
<b>Thoracotomy</b>						
94700	- insertion of chest tube (IOP) .....	72.36	24.51	80.40	4	4
94702	- rib resection for drainage or biopsy (IOP) .....		49.02	289.44	6	6
94704	- exploratory or removal of foreign body .....		106.21	378.12	13	13
94706	- thoracotomy with or without biopsy .....		106.21	378.12	13	13
94708	- thoracotomy for post operative haemorrhage or empyema .....		106.21	378.12	13	13
94710	- thoracotomy with repair of ruptured diaphragm .....		106.21	512.85	13	13
94712	<b>Insertion of permanent pleural drainage catheter.....</b>			<b>200.00</b>	<b>6</b>	<b>6</b>
94714	<b>Removal of permanent pleural drainage catheter.....</b>			<b>67.39</b>	<b>6</b>	<b>6</b>
<b>Notes:</b>						
<i>i) Not to be billed for simple thoracocentesis or placement of a temporary pigtail drainage catheter</i>						
<i>ii) The fees for codes 94712 &amp; 94714 include payment for local anaesthesia, thoracocentesis, aspiration, drainage and ultrasonic guidance by the physician who performs the procedure</i>						
94716	Decortication of lung with muscle graft and closure of pleural fistula.....		122.55	574.54	15	15
94718	Intercostal drainage with sclerosing agent (IOP).....		49.02	132.97	6	6
<b>Excision</b>						
Biopsy of pleura or lung						
94730	- peripheral or parietal - including thoracotomy (IOP) ..		106.21	196.53	13	13
94732	- hilar - including thoracotomy .....		106.21	286.49	13	13
94734	Pneumonectomy - complete.....		106.21	926.17	14	14
Lobectomy						
94746	- complete .....		106.21	926.17	13	13
94748	- segmental resection.....		106.21	926.17	13	13
94750	- wedge resection.....		106.21	482.40	13	13
94754	- plus decortication.....		122.55	IC	15	15
94770	Excision of broncho-pleural fistula.....		81.70	IC	13	13
94772	Pleurectomy-pleural decortication .....		81.70	562.80	15	15
94774	Sleeve resection with lobectomy .....		114.38	993.90	13	13
94780	Lung transplantation.....		IC	IC	IC	IC

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>GENERAL FEES</b>						
<b>Bone/Fascial/Dermis Grafts</b>						
<i>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.</i>						
90800	Autogenous - separate incision.....			84.38		
90802	- same incision .....			56.90		
90804	- different surgeon (IOP).....			187.84		
90806	Homogenous - bank..... add			24.20		
90808	Allograft - donor- 85% of excision fee .....			IC		
90810	- cadaver - each long bone .....			140.90		
<b>Fixation</b>						
90830	Methyl methacrylate (not arthroplasty).....			57.76		
90832	Rigid external fixation (excluding casts) for closed reduction..... add			55.93		
90834	Cast - bracing with closed reduction .....	50.34		55.93		
90836	Percutaneous pinning .....			41.95		
90838	Rigid external fixation - pseudoarthrosis.....			74.11		
Removal of internal fixation device						
90840	- general anaesthetic.....		24.51	154.45	4	4
90842	- local anaesthetic .....			104.27		
90844	Removal of extensive external fixation device under general anaesthetic .....			47.32	4	4
90846	Insertion traction pin - excludes fractures and dislocations (IOP).....			32.86		
<b>Wound Care</b>						
90860	Secondary closure .....			94.54		
90862	Closed irrigation during a surgical procedure.....			61.41		
90866	Excision of foreign body.....			104.76	4	4
<b>Electrical Stimulation</b>						
90870	External or internal (IOP) .....			187.84	4	4
<b>Casts (IOP)</b>						
<i>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.</i>						
90900	Finger.....	10.76		11.96		
90902	Hand .....	16.16		17.95	4	4
90904	Arm, forearm or wrist .....	25.85		28.72	4	4
90906	Foot.....	16.16		17.95	4	4
90908	Below knee, knee splints (Stove pipe, etc.) .....	25.85		28.72	4	4
90910	Whole leg (mid thigh to toes) .....	31.35		34.83	4	4
90912	Toes.....	10.76		11.96		
90914	Head and torso .....	105.17	24.51	116.85	4	4

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>GENERAL FEES (Cont'd)</b>						
<b>Casts (IOP) (Cont'd)</b>						
90916	Shoulder spica.....	105.17	24.51	116.85	4	4
90918	Body cast.....	62.34		69.27	4	4
90920	Hip spica - unilateral.....	105.17		116.85	4	4
90922	- bilateral.....	131.61		146.23	4	4
90924	Wedging of casts in other than fracture treatment.....	10.76		11.96		
90926	Application of Unna's paste.....	16.16		17.95		
90928	Application of cast brace (must include hinge).....	73.11		81.23		
90930	Removal of plaster (not associated with fractures or dislocations within 4 weeks of initial treatment).....	10.76		11.96		

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>HAND AND WRIST</b>						
<b>Amputation</b>						
90950	Phalanx.....			157.14	4	4
90952	- each additional..... add			45.82		
90954	Metacarpal or metaphalangeal joint.....			185.10	4	4
90956	- each additional..... add			80.41		
90958	Transmetacarpal 2 <sup>nd</sup> or 5 <sup>th</sup> ray.....			271.47	4	4
90960	Hand - all metacarpals.....	24.51		281.79	4	4
90962	Wrist.....		32.68	281.79	5	5
<b>Arthrodesis</b>						
90970	Finger, thumb.....		24.51	249.74	4	4
90972	Wrist.....		24.51	379.35	4	4
<b>Arthroplasty</b>						
90980	Wrist - interposition.....		24.51	364.02	5	5
90982	- total.....		49.02	415.05	6	6
90984	Removal only.....		24.51	187.84	6	6
90986	Hand - interposition - single.....		24.51	247.16	5	5
90988	- multiple.....		24.51	447.11	6	6
90990	Single joint - total.....		24.51	282.71	5	5
90992	Multiple joints - total max.....		24.51	753.74	6	6
90994	Removal only.....		24.51	140.90	4	4
90996	Carpal replacement.....		24.51	312.98	5	5
90998	Revision of arthroplasty..... add			139.82		
<b>Arthroscopy</b>						
91010	Diagnostic arthroscopy (sole procedure).....		24.51	178.86	4	4
91012	Synovial biopsy.....			42.81		
91014	Removal of loose body, screw.....			187.84		
91016	Drilling of defect (includes removal of loose body).....			245.55		
91018	Debridement - local.....			245.55		
91020	- total.....			318.69		
91022	Synovectomy - partial.....			191.39		
91024	- total.....			469.58		
91026	Pinning of osteochondral fragment.....			245.55		
91028	Arthroscopy in association with surgery including 91012 to 91026 - same surgeon..... add			134.26		
<b>Arthrotomy</b>						
91040	Finger.....			163.05	4	4
91042	Wrist.....		24.51	207.26	4	4
<b>Biopsy</b>						
91050	Bones - punch, x-ray control (IOP).....			70.45	4	4
91052	- open biopsy or taking of bone graft by other than operating surgeon (IOP).....		32.68	140.90	4	4
91054	Joint - via arthroscope.....			10.65		
91056	- needle (IOP).....			47.43		
91058	- open finger.....			163.05	4	4
91060	- open wrist.....		24.51	207.26	4	4
91062	Muscle (IOP).....			103.05	4	4

## SURGICAL PROCEDURES

## OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>HAND AND WRIST (Cont'd)</b>						
<b>Decompression - Denervation</b>						
91070	Decompression median nerve at wrist .....		24.51	<b>177.95</b>	4	4
91072	Exploration and/or decompression and/or transposition and/or neurolysis of major nerve (excluding median nerve at wrist) .....		32.68	<b>243.93</b>	4	4
<b>Incision and Drainage (e.g. Osteomyelitis)</b>						
91080	Incision and drainage - phalanx/metacarpal/carpus.....		24.51	<b>177.68</b>	4	4
91082	Sequestrectomy - phalanx/metacarpal/carpus.....		24.51	<b>140.90</b>	4	4
91084	Saucerization and bone graft - phalanx/metacarpal/carpus.....		24.51	<b>235.76</b>	4	4
91086	Incision and drainage - joint (finger).....			<b>163.05</b>	4	4
91088	- joint (wrist) .....		24.51	<b>207.26</b>	4	4
91090	Tendon sheath .....		24.51	<b>163.07</b>	4	4
<b>Examination/Manipulation</b>						
91100	Manipulation - hand/wrist - under general anaesthetic (IOP) .....			<b>23.02</b>	4	4
<b>Excision - Bone</b>						
91110	Proximal row carpectomy .....		24.51	<b>329.66</b>	5	5
91112	Carpal - bone (1) .....		24.51	<b>208.66</b>	4	4
91114	Dorsal exostosis (triquetrum) .....		24.51	<b>204.64</b>	4	4
91116	Radial styloid.....		24.51	<b>228.12</b>	4	4
91118	Phalanx/metacarpal.....		24.51	<b>207.58</b>	4	4
91120	Bone tumour.....		IC	IC	IC	IC
<b>Excision - Joint</b>						
91130	Synovectomy/capsulectomy/debridement - finger joint .....		24.51	<b>219.95</b>	4	4
91132	2 or more joints .....		24.51	<b>330.09</b>	4	4
91134	Synovectomy - extensor or flexor tendons .....			<b>219.09</b>	4	4
91136	Synovectomy/debridement - wrist .....		24.51	<b>334.39</b>	4	4
91138	Radio-ulnar meniscectomy.....		24.51	<b>225.60</b>	4	4
<b>Excision - Muscle and Tendon</b>						
91150	Muscle - simple .....		24.51	<b>187.84</b>	4	4
91152	- complex .....		32.68	<b>471.52</b>	6	6
91154	Tendon sheath - single .....		24.51	<b>235.76</b>	4	4
91156	- each additional (max of 1) .....			<b>83.89</b>		
91158	Fascia for Dupuytren's - simple or complex with or without flaps or grafts .....		24.51	<b>401.22</b>	4	4
<b>Excision - Ganglion</b>						
91170	Simple or complex.....	<b>136.02</b>	24.51	<b>151.13</b>	4	4

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>HAND AND WRIST (Cont'd)</b>						
<b>Reconstruction - Bone</b>						
Osteotomy						
91180	- phalanx - terminal.....			<b>173.03</b>	4	4
91182	- phalanx - middle, proximal or metacarpal.....		24.51	<b>188.44</b>	4	4
91184	- each additional .....			<b>41.52</b>		
91186	Pseudoarthrosis - phalanx, metacarpal.....		24.51	<b>253.35</b>	4	4
91188	- scaphoid.....		24.51	<b>309.23</b>	4	4
<b>Reconstruction - Ligaments</b>						
91200	Simple/single repair - wrist.....		24.51	<b>256.36</b>	4	4
91202	Extensive/multiple repair - wrist.....		24.51	<b>434.73</b>	4	4
91204	Metacarpal phalangeal repair .....		24.51	<b>269.24</b>	4	4
<b>Reconstruction - Tendon</b>						
91210	Tenoplasty - 1 .....		24.51	<b>217.91</b>	4	4
91212	- each additional .....			<b>74.64</b>		
91214	Tendon graft - 1.....		24.51	<b>324.86</b>	4	4
91216	- each additional (max of 1).....			<b>117.88</b>		
91218	Reconstruction of flexor tendon pulley, per finger.....			<b>96.58</b>	4	4
91220	Silicone rod insertion- 1 .....		24.51	<b>287.17</b>	4	4
91222	- each additional .....			<b>209.02</b>		
91224	Transplant/transfer - single.....		24.51	<b>278.08</b>	4	4
91226	- each additional ( max. of 1).....			<b>200.69</b>		
91228	Tendon repair - extensor - single .....	<b>125.54</b>		<b>139.49</b>	4	4
91230	- each additional.....			<b>60.31</b>		
91232	Tendon repair - flexor - single .....		24.51	<b>261.46</b>	4	4
91234	- each additional .....			<b>109.61</b>		
Mallet finger - closed						
91238	- K-wire.....	VF		VF		
91240	- open.....		24.51	<b>143.59</b>	4	4
Boutonniere - closed						
91242	- open .....	VF		VF		
91244	- late.....		24.51	<b>240.60</b>	4	4
<b>Reconstruction - Extremities</b>						
91250	Pollicization.....		49.02	<b>577.14</b>	6	6
91252	Digital reimplantation involving microvascular and neuro anastomosis .....		65.36	<b>1548.15</b>	8	8
91254	Revision of 91250 or 91252.....		65.36	IC	8	8
91258	Reconstruction and plastic repair of traumatically amputated extremities .....		65.36	IC	8	8



**SURGICAL PROCEDURES**

**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>HAND AND WRIST (Cont'd)</b>						
<b>Release - Tendon</b>						
91270	Tenolysis - flexor and/or extensor tendon of 1 digit .....		24.51	<b>189.40</b>	4	4
91272	- each additional digit (max of 2)..... add			<b>140.42</b>		
91274	Flexor tenolysis with pulley preservation .....		24.51	<b>282.49</b>	4	4
	Tenotomy or fasciotomy (closed) (IOP)					
91276	- finger - 1.....			<b>48.40</b>	4	4
91278	- 2.....			<b>71.31</b>	4	4
91280	- 3 or more .....			<b>96.80</b>	4	4
91282	- palmar or plantar.....			<b>71.85</b>	4	4
	Tendon release (open)					
91284	- finger, palm .....			<b>152.18</b>	4	4
91286	- wrist .....		24.51	<b>190.08</b>	4	4
91288	- more than 1 .....			<b>126.44</b>		
	..... add					
<b>Reduction - Fractures</b>						
91300	Phalanx - no reduction, rigid immobilization .....	<b>43.66</b>		<b>48.51</b>		
91302	- closed.....	<b>87.70</b>		<b>97.44</b>	4	4
91304	- each additional .....			<b>21.40</b>		
91306	- open .....		32.68	<b>211.40</b>	4	4
91307	- extensive debridement of compound fracture .....			<b>38.98</b>		
	..... add					
91308	Metacarpal - no reduction, 1 or more, rigid immobilization .....	<b>43.66</b>		<b>48.51</b>		
91310	- closed, 1 or more .....	<b>87.70</b>		<b>97.44</b>	4	4
91312	- open.....		32.68	<b>186.02</b>	4	4
91314	- each additional (open) .....			<b>121.47</b>		
91315	- extensive debridement of compound fracture .....			<b>38.98</b>		
	..... add					
91316	Intra-articular - closed .....			<b>76.69</b>		
91318	- open .....		32.68	<b>164.24</b>	4	4
91319	- extensive debridement of compound fracture .....			<b>30.67</b>		
	..... add					
91320	Bennett's - no reduction, rigid immobilization .....			<b>48.51</b>		
91322	- closed.....	97.88	24.51	<b>116.97</b>	4	4
91324	- open .....		32.68	<b>237.87</b>	4	4
91325	- extensive debridement of compound fracture .....			<b>46.79</b>		
	..... add					
91326	Carpus - no reduction, rigid immobilization.....	40.59		<b>48.51</b>		
91328	- closed, 1 or more .....			<b>111.96</b>	4	4
91330	- open, 1 or more.....		32.68	<b>215.86</b>	4	4
91331	- extensive debridement of compound fracture .....			<b>44.79</b>		
	..... add					
91332	Scaphoid - no reduction, rigid immobilization.....	<b>43.66</b>		<b>48.51</b>		
91334	- open.....		32.68	<b>267.71</b>	4	4
91336	- excision.....		32.68	<b>187.90</b>	4	4

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>HAND AND WRIST (Cont'd)</b>						
<b>Reduction - Dislocations</b>						
91350	Finger - closed - 1 .....	<b>51.01</b>		<b>56.68</b>	4	4
91352	- each additional.....add			<b>9.90</b>		
91354	- open .....		24.51	<b>191.77</b>	4	4
91355	- extensive debridement of compound fracture add			<b>22.67</b>		
91356	Metacarpal/phalangeal - closed - 1 .....	<b>50.91</b>		<b>56.57</b>	4	4
91358	- each additional.....add			<b>9.90</b>		
91360	- open .....		24.51	<b>177.04</b>	4	4
91361	- extensive debridement of compound fracture .....			<b>22.63</b>		
91362	Carpal - closed.....			<b>124.66</b>	4	4
91364	- open .....		24.51	<b>234.79</b>	4	4
91365	- extensive debridement of compound fracture add			<b>49.86</b>		

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>ELBOW AND FOREARM</b>						
<b>Amputation</b>						
91370	Through radius and ulna .....		32.68	298.03	5	5
91372	Elbow disarticulation.....		32.68	281.79	5	5
<b>Arthrodesis</b>						
91380	Elbow .....		24.51	379.35	4	4
<b>Arthroplasty</b>						
91390	Ulna replacement (lower end) .....		24.51	289.00	4	4
91392	Implant radial head.....		24.51	244.79	4	4
91394	Removal of total replacement.....		24.51	392.04	7	7
91396	Complete arthroplasty replacement .....		49.02	476.47	8	8
91398	Interposition arthroplasty .....		49.02	424.30	7	7
91400	Revision of elbow arthroplasty .....			125.84		
<b>Arthroscopy</b>						
91410	Diagnostic arthroscopy (sole procedure).....		24.51	178.86	4	4
91412	Synovial biopsy .....			42.81		
91414	Removal of loose body, screw .....			187.84		
91416	Drilling of defect (includes removal of loose body) .....			245.55		
91418	Debridement - local.....			245.55		
91420	- total .....			318.69		
91422	Synovectomy - partial .....			191.39		
91424	- total .....			469.58		
91426	Pinning of osteochondral fragment.....			245.55		
91428	Arthroscopy in association with surgery including 91412 to 91426 - same surgeon.....			134.26		
<b>Arthrotomy</b>						
91440	Elbow, loose body, etc. ....		24.51	194.24	4	4
<b>Biopsy</b>						
91450	Bone - needle (IOP).....			70.99		
91452	- open (IOP) .....		32.68	140.90	4	4
91454	Joint - via arthroscope .....			10.65		
91456	- open.....		24.51	167.46	4	4
91458	Muscle/soft tissue (IOP) .....			103.05	4	4
<b>Decompression/Denervation</b>						
91470	Fasciotomy for compartments syndrome (not including secondary closure).....		24.51	312.55	4	4
91472	Secondary closure.....			103.05	4	4
91474	Catheter - insertion (IOP) .....			47.43		
	- monitoring.....	VF		VF		
91478	Exploration and/or decompression and/or transposition and/or neurolysis of ulnar nerve (elbow) .....		32.68	207.37	4	4
91480	Denervation - elbow .....		24.51	250.60	4	4

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>ELBOW AND FOREARM (Cont'd)</b>						
<b>Incision and Drainage (osteomyelitis)</b>						
91490	Acute, incision and drainage.....		24.51	<b>294.43</b>	4	4
91492	Sequestrectomy.....		24.51	<b>345.90</b>	4	4
91494	Saucerization and bone grafting.....		24.51	<b>440.33</b>	4	4
91496	Soft tissue or bursa, incision and drainage.....			<b>94.54</b>	4	4
91498	Elbow, incision and drainage.....		24.51	<b>194.24</b>	4	4
<b>Examination/Manipulation</b>						
91510	Manipulation under general anaesthetic (IOP).....			<b>23.02</b>	4	4
<b>Excision - Bone</b>						
91520	Radial head.....		24.51	<b>211.83</b>	4	4
91522	Radial styloid.....		24.51	<b>228.12</b>	4	4
91524	Ulna lower end.....		24.51	<b>187.84</b>	4	4
91526	Olecranon.....		24.51	<b>202.31</b>	4	4
91528	Olecranon with fascial repair.....		24.51	<b>300.78</b>	4	4
<b>Excision - Bursae</b>						
91540	Olecranon.....	<b>88.87</b>	24.51	<b>98.74</b>	4	4
<b>Excision - Joint Contents</b>						
91550	Synovectomy/capsulectomy/debridement, etc. ....		24.51	<b>303.52</b>	4	4
<b>Excision - Muscles</b>						
91560	Myositis ossificans.....		32.68	<b>281.79</b>	5	5
91562	Foreign body removal.....			<b>104.76</b>	4	4
<b>Excision - Soft Tissues Tumours</b>						
91570	- superficial.....			<b>191.23</b>	4	4
91572	- deep.....		40.85	<b>471.52</b>	6	6
<b>Excision - Bone Tumours</b>						
91580	Exostosis.....		32.68	<b>160.31</b>	4	4
91582	Simple excision.....		32.68	<b>281.36</b>	4	4
91584	Extensive with replacement.....		32.68	<b>659.42</b>	6	6
<b>Reconstruction - Bone - Pseudoarthrosis</b>						
91590	Radius or ulna.....		24.51	<b>295.99</b>	4	4
91592	Radius and ulna.....		24.51	<b>400.21</b>	4	4
<b>Reconstruction - Bone - Osteotomy</b>						
91600	Radius or ulna.....		24.51	<b>289.54</b>	4	4
91602	Radius and/or ulna and reconstruction congenital abnormality, synostosis, etc. ....		24.51	<b>386.98</b>	4	4
<b>Reconstruction - Fascial Defects</b>						
91610	- small.....		24.51	<b>141.97</b>	4	4
91612	- large with or without synthetic graft or rotation flap ....		32.68	<b>282.22</b>	5	5

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>ELBOW AND FOREARM (Cont'd)</b>						
<b>Reconstruction - Ligaments</b>						
91620	Simple/single repair.....		24.51	<b>225.81</b>	4	4
91622	Extensive/multiple repair .....		24.51	<b>382.57</b>	4	4
<b>Reconstruction - Tendons</b>						
91630	Suture extensor tendon - single.....	<b>111.51</b>	24.51	<b>123.90</b>	4	4
91632	- each additional .....			<b>45.82</b>		
91634	Suture flexor tendon - single .....		24.51	<b>251.00</b>	4	4
91636	- each additional .....			<b>93.55</b>		
91638	Tenoplasty - single .....		24.51	<b>217.91</b>	4	4
91640	- each additional.....			<b>74.64</b>		
91642	Tenolysis - single .....		24.51	<b>196.93</b>	4	4
91644	- each additional (max. of 2).....			<b>84.86</b>		
Transposition/transplantation/transfer						
91646	- single .....		24.51	<b>278.08</b>	4	4
91648	- each additional (max. of 1) .....			<b>89.70</b>		
91650	Steindler flexoplasty .....		24.51	<b>336.49</b>	5	5
<b>Release</b>						
91660	Muscles and tendons - simple .....		32.68	<b>132.78</b>	4	4
91662	- radical, e.g., muscle slide.....		40.85	<b>306.21</b>	5	5
<b>Reduction - Dislocations</b>						
91670	Elbow joint - closed reduction.....	<b>74.15</b>		<b>82.39</b>	4	4
91672	- open reduction, acute .....		24.51	<b>245.44</b>	4	4
91674	- repair chronic, recurrent.....		24.51	<b>369.45</b>	4	4
91676	Radial head - closed reduction .....	<b>34.65</b>		<b>38.50</b>	4	4
91678	- open reduction - acute.....		24.51	<b>187.84</b>	4	4
91680	- recurrent .....		24.51	<b>221.24</b>	6	6
91682	- late.....		32.68	<b>347.72</b>	6	6
<b>Reduction - Fractures</b>						
Epicondyle						
91690	- no reduction .....			<b>65.72</b>		
91692	- closed reduction.....		24.51	<b>122.40</b>	4	4
91694	- open reduction .....		32.68	<b>208.23</b>	4	4
91695	- extensive debridement of compound fracture .....			<b>48.96</b>		
Transcondylar/condylar						
91696	- no reduction .....	<b>59.15</b>		<b>65.72</b>		
91698	- closed reduction.....		24.51	<b>200.91</b>	4	4
91700	- closed reduction with traction .....		24.51	<b>304.38</b>	4	4
91702	- open reduction .....		32.68	<b>375.80</b>	4	4
91703	- extensive debridement of compound fracture .....			<b>80.37</b>		
Olecranon						
91704	- no reduction, rigid immobilization.....			<b>122.40</b>	4	4
91706	- closed reduction.....		24.51	<b>125.52</b>	4	4
91708	- open reduction .....		32.68	<b>218.55</b>	4	4
91709	- extensive debridement of compound fracture .....			<b>50.21</b>		

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>ELBOW AND FOREARM (Cont'd)</b>						
<b>Reduction - Fractures (Cont'd)</b>						
Radius and ulnar shaft						
91710	- no reduction, rigid immobilization .....			<b>65.72</b>		
91712	- closed reduction .....	<b>130.05</b>	24.51	<b>144.50</b>	4	4
91714	- open reduction .....		32.68	<b>358.59</b>	4	4
91715	- extensive debridement of compound fracture .....add			<b>57.80</b>		
Radius and ulna-Monteggia						
91716	- no reduction, rigid immobilization .....			<b>65.72</b>		
91718	- closed reduction .....	<b>126.81</b>		<b>140.90</b>	4	4
91720	- open reduction of ulna plus closed reduction radial head.....		24.51	<b>235.76</b>	4	4
91721	- extensive debridement of compound fracture .....add			<b>56.36</b>		
Radius or ulna						
91722	- no reduction, rigid immobilization .....	<b>59.15</b>		<b>65.72</b>		
91724	- closed reduction .....	<b>103.00</b>	24.51	<b>114.44</b>		4
91726	- open reduction .....		32.68	<b>222.21</b>		4
91727	- extensive debridement of compound fracture .....add			<b>45.78</b>		
Radius-distal, Colles', Smith's, Barton's, etc.						
91728	- no reduction, rigid immobilization .....	<b>59.15</b>		<b>65.72</b>		
91730	- closed reduction .....	<b>107.54</b>	24.51	<b>119.49</b>	4	4
91732	- open reduction .....		32.68	<b>281.15</b>	4	4
91733	- extensive debridement of compound fracture .....add			<b>42.72</b>		
91734	Osteochondral - open reduction.....		32.68	<b>244.58</b>		5

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>SHOULDER/ARM/CHEST</b>						
<b>Amputation</b>						
91750	Forequarter .....		81.70	<b>477.87</b>	15	15
91752	Shoulder disarticulation .....		73.53	<b>362.68</b>	9	9
91754	High humerus .....		32.68	<b>359.45</b>	5	5
<b>Arthrodesis</b>						
91760	Shoulder .....		32.68	<b>456.14</b>	6	6
<b>Arthroplasty</b>						
91770	Humeral prosthesis .....		32.68	<b>436.94</b>	6	6
91772	Total prosthesis .....		49.02	<b>676.09</b>	10	10
91774	Revision total arthroplasty shoulder .....		49.02	<b>917.71</b>	10	10
91776	Removal prosthesis/no replacement .....		24.51	<b>386.55</b>	8	8
91778	Revision of prosthesis .....			<b>194.67</b>		
<b>Arthroscopy</b>						
91790	Diagnostic arthroscopy (sole procedure) .....		24.51	<b>178.86</b>	4	4
91792	Synovial biopsy .....			<b>42.81</b>		
91794	Removal of loose body, screw .....			<b>187.84</b>		
91796	Drilling of defect (includes removal of loose body) .....			<b>245.55</b>		
91798	Debridement - local .....			<b>245.55</b>		
91800	- total .....			<b>318.69</b>		
91802	Synovectomy - partial .....			<b>191.39</b>		
91804	- total .....			<b>469.58</b>		
91806	Pinning of osteochondral fragment .....			<b>245.55</b>		
91808	Arthroscopy in association with surgery including 91792 to 91806 - same surgeon .....			<b>134.26</b>		
<b>Arthrotomy</b>						
91820	Shoulder .....		24.51	<b>217.42</b>	4	4
<b>Biopsy</b>						
91830	Bones - needle/punch, x-ray control (IOP) .....			<b>70.45</b>	4	4
91832	- open (IOP) .....		32.68	<b>140.90</b>	4	4
91834	Joint - via arthroscope .....			<b>10.65</b>		
91836	- open .....		32.68	<b>217.42</b>	4	4
91838	Soft tissue - open (IOP) .....			<b>103.05</b>	4	4
<b>Incision and Drainage</b>						
91850	Humerus/clavicle/scapula - incision and drainage .....		32.68	<b>255.66</b>	4	4
91852	Sequestrectomy .....		32.68	<b>282.22</b>	4	4
91854	Saucerization with bone graft .....		32.68	<b>377.52</b>	4	4
91856	Bursae/soft tissue .....	<b>85.09</b>		<b>94.54</b>	4	4
91858	Joint .....		32.68	<b>217.42</b>	4	4
<b>Examination and Manipulation</b>						
91870	Manipulation under general anaesthetic (IOP) .....			<b>47.43</b>	4	4

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>SHOULDER/ARM/CHEST (Cont'd)</b>						
<b>Excision - Clavicle or Acromion</b>						
91880	Simple (includes ligament).....		32.68	<b>205.70</b>	4	4
91882	Major tumour.....		40.85	<b>282.22</b>	6	6
91884	Malignant tumour with reconstruction .....		40.85	<b>471.52</b>	6	6
<b>Excision - Humerus</b>						
91890	Head .....		32.68	<b>291.80</b>	5	5
91892	Exostosis .....		32.68	<b>160.31</b>	4	4
91894	Benign tumour .....		32.68	<b>281.36</b>	4	4
91896	Malignant tumour with reconstruction .....		32.68	<b>662.97</b>	6	6
<b>Excision - Joint</b>						
91900	Synovectomy and debridement .....		32.68	<b>413.23</b>	5	5
91902	Excision of subacromial bursae .....		24.51	<b>205.43</b>	4	4
91904	Muscle/fascia - simple .....		24.51	<b>204.75</b>	4	4
91906	- complex .....		32.68	<b>471.52</b>	6	6
91908	Rotator cuff exploration (includes acromioplasty, excision of coraco-acromial ligament) .....		32.68	<b>201.45</b>	4	4
91910	Acromio/sterno-clavicular meniscectomy.....		24.51	<b>204.14</b>	4	4
<b>Reconstruction - Pseudoarthrosis and Osteotomy</b>						
91920	Pseudoarthrosis - clavicle.....		32.68	<b>261.47</b>	4	4
91922	- humerus.....		32.68	<b>336.97</b>	4	4
91924	Osteotomy - humerus .....		32.68	<b>284.27</b>	4	4
91926	- clavicle .....		32.68	<b>205.70</b>	4	4
91928	- glenoid.....		32.68	<b>271.47</b>	4	4
<b>Reconstruction - Muscles/Soft Tissues</b>						
91940	Muscle transplant - pectoralis major .....		49.02	<b>422.26</b>	6	6
91942	Muscle/tendon release.....		40.85	<b>306.21</b>	5	5
91944	Release- sternomastoid .....		40.85	<b>287.71</b>	5	5
91946	Scapulopexy - congenital evaluation .....		49.02	<b>374.83</b>	6	6
91948	Trapezius/sternomastoid/transplant.....		32.68	<b>329.66</b>	4	4
91950	Tendon repair - biceps.....		24.51	<b>221.51</b>	4	4
91952	Rotator cuff repair - simple, end to end or side to side (includes acromioplasty, excision of coraco-acromial ligament).....		32.68	<b>308.04</b>	5	5
91954	Rotator cuff repair - complex (includes implantation into bone, and as required, acromioplasty, excision of coraco-acromial ligament, excision of distal clavicle)....		32.68	<b>453.88</b>	5	5
<b>Reduction - Fractures</b>						
91960	Tuberosity - no reduction.....	<b>59.15</b>		<b>65.72</b>		
91962	- closed reduction .....	<b>103.24</b>	24.51	<b>114.71</b>	4	4
91964	- open reduction (without cuff tear).....		32.68	<b>282.22</b>	4	4
91965	- extensive debridement of compound fracture .....add			<b>45.88</b>		



**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>SHOULDER/ARM/CHEST (Cont'd)</b>						
<b>Reduction - Fractures (Cont'd)</b>						
Neck without dislocation of head						
91966	- no reduction.....	<b>59.15</b>		<b>65.72</b>		
91968	- closed reduction.....	<b>116.64</b>		<b>129.60</b>	4	4
91970	- open reduction.....		40.85	<b>296.50</b>	6	6
91971	- extensive debridement of compound fracture..... add			<b>51.84</b>		
Neck with dislocation of head						
91972	- no reduction.....			<b>65.72</b>		
91974	- closed reduction.....		24.51	<b>178.86</b>	4	4
91976	- open reduction.....		40.85	<b>385.15</b>	6	6
91977	- extensive debridement of compound fracture..... add			<b>71.55</b>		
91978	Shaft - no reduction.....			<b>65.72</b>		
91980	- closed reduction.....		24.51	<b>143.59</b>	4	4
91982	- open reduction.....		32.68	<b>314.54</b>	4	4
91983	- extensive debridement of compound fracture..... add			<b>57.43</b>		
Clavicle						
	- no reduction.....	VF		VF		
91984	- closed reduction with anaesthetic.....		24.51	<b>60.88</b>	4	4
91986	- open reduction.....		32.68	<b>224.90</b>	4	4
91987	- extensive debridement of compound fracture..... add			<b>24.35</b>		
Scapula						
91988	- no reduction.....			<b>65.72</b>		
91990	- closed reduction with anaesthetic.....		24.51	<b>112.88</b>	4	4
91992	- open reduction.....		32.68	<b>235.76</b>	5	5
91993	- extensive debridement of compound fracture..... add			<b>45.15</b>		
Sternum						
91994	- no reduction.....			<b>65.72</b>		
91996	- closed reduction.....			<b>112.88</b>		
91998	- open reduction - pleura open.....		73.53	IC	13	13
92000	- pleura closed.....		32.68	IC	4	4
92001	- extensive debridement of compound fracture..... add			<b>45.15</b>		
Ribs						
	- no reduction.....	VF		VF		
92004	- complicated - pleura open.....		73.53	IC	13	13
92006	- pleura closed.....		32.68	IC	4	4
<b>Reduction - Dislocations</b>						
Acromio-clavicular/sterno-clavicular						
92010	- no reduction.....			<b>65.72</b>		
92012	- closed with anaesthetic.....		32.68	<b>130.73</b>	4	4
92014	- open reduction.....		32.68	<b>224.90</b>	4	4
92016	- open reduction - late.....		32.68	<b>279.10</b>	4	4
Glenohumeral joint						
92018	- closed reduction - without anaesthetic.....	<b>42.69</b>		<b>47.43</b>		
92020	- with anaesthetic.....	<b>97.28</b>		<b>108.09</b>	4	4
92022	- open reduction - early.....		32.68	<b>314.81</b>	6	6
92024	- late.....		32.68	<b>565.42</b>	7	7
92026	- recurrent.....		40.85	<b>369.45</b>	5	5

## SURGICAL PROCEDURES

## OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>SKULL AND MANDIBLE</b>						
<b>Arthroplasty</b>						
92040	Temporo-mandibular joint - unilateral .....		40.85	<b>336.49</b>	5	5
<b>Biopsy (IOP)</b>						
92050	Bones - punch, simple .....			<b>41.81</b>	4	4
92052	- punch, x-ray control .....			<b>103.05</b>	4	4
92054	- open .....		32.68	<b>204.75</b>	4	4
<b>Incision and Drainage</b>						
92060	Mandibular sequestrectomy (IOP) .....		57.19	<b>271.25</b>	7	7
<b>Excision</b>						
92070	Bone - tumour .....		IC	IC	IC	IC
92072	Maxilla, with exenteration of orbit and skin graft .....		32.68	<b>513.04</b>	7	7
92074	Maxilla advancement .....		32.68	<b>424.09</b>	8	8
92076	Mandible .....		32.68	<b>340.52</b>	7	7
92078	Mandibular condyle .....		32.68	<b>266.63</b>	5	5
92080	Temporo-mandibular menisectomy .....		24.51	<b>240.82</b>	5	5
<b>Reconstruction</b>						
92090	Facial paralysis - static slings .....		32.68	<b>295.94</b>	5	5
92092	- dynamic slings .....		32.68	<b>384.40</b>	6	6
92094	Composite repair for facial paralysis, plication of paralyzed muscles, and resection for paralysis of over active muscles .....		32.68	<b>491.74</b>	7	7
92096	- with meloplasty .....			<b>83.89</b>		
<b>Orthognathic Surgery</b>						
Anterior dento-alveolar osteotomy, maxilla or mandible						
92100	- 1 segment .....		49.02	<b>775.15</b>	10	10
92102	- 2 segments .....		49.02	<b>898.84</b>	10	10
Posterior dento-alveolar osteotomy, maxilla						
92104	- 1 side .....		49.02	<b>775.15</b>	10	10
92106	- both sides, single segment .....		49.02	<b>898.84</b>	10	10
92108	- both sides, separate segments .....		49.02	<b>1143.95</b>	10	10
Posterior dento-alveolar osteotomy, mandible						
92110	- 1 side .....		49.02	<b>775.15</b>	10	10
92112	- both sides .....		49.02	<b>1143.95</b>	10	10
Total U dento-alveolar osteotomy						
92114	- mandible .....		49.02	<b>1183.10</b>	10	10
92116	- maxilla .....		49.02	<b>1267.43</b>	10	10
92118	Mandibular or maxillary visor osteotomy for alveolar hypoplasia .....		49.02	<b>1104.05</b>	10	10
Genioplasty						
92120	- 1 segment .....		49.02	<b>246.62</b>	10	10
92122	- 2 segments, or for laterognathia .....		49.02	<b>369.67</b>	10	10
92124	- 3 segments .....		49.02	<b>492.76</b>	10	10
Mandibular osteotomies for prognathism						
92126	- subcondylar .....		24.51	<b>404.73</b>	6	6
92128	- vertical ramus .....		49.02	<b>897.98</b>	10	10
92130	- sagittal split .....		49.02	<b>897.98</b>	10	10

**SURGICAL PROCEDURES**

**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>SKULL AND MANDIBLE (Cont'd)</b>						
<b>Orthognathic Surgery (Cont'd)</b>						
Mandible osteotomies for retrognathia, any technique						
92140	- advancement - up to 10 mm .....		49.02	<b>897.98</b>	10	10
92142	- 10 to 20 mm .....		49.02	<b>1020.48</b>	10	10
92144	- greater than 20 mm .....		49.02	<b>1307.44</b>	10	10
92146	- for apertognathia or laterognathia..... add			<b>246.62</b>		
LeFort I advancement						
92148	- in 1 segment .....		81.70	<b>774.40</b>	20	20
92150	- in 2 segments .....			<b>285.77</b>		
92152	- in 3 segments .....			<b>572.51</b>		
LeFort I intrusion						
92154	- in 1 segment .....		81.70	<b>1020.48</b>	20	20
92156	- in 2 segments .....			<b>285.77</b>		
92158	- in 3 segments .....			<b>572.51</b>		
LeFort I extrusion						
92160	- in 1 segment .....		81.70	<b>1267.43</b>	20	20
92162	- in 2 segments .....			<b>285.77</b>		
92164	- in 3 segments .....			<b>572.51</b>		
LeFort I cleft palate						
92166	- in 1 segment .....		81.70	<b>1469.09</b>	20	20
92168	- in 2 segments .....			<b>246.62</b>		
92170	- in 3 segments .....			<b>493.25</b>		
92172	- with SMR..... add			<b>197.52</b>		
92174	- with pharyngoplasty .....			<b>295.94</b>		
92176	- with closure alveolar fistula with or without bone graft .....			<b>369.67</b>		
92178	- with closure hard palate fistula with or without bone graft .....			<b>493.25</b>		
92180	Naso-maxillary osteotomy without LeFort I .....		49.02	<b>774.40</b>	10	10
92182	LeFort II maxillary osteotomy and advancement.....		81.70	<b>1390.90</b>	20	20
92184	Construction glenoid fossa and zygomatic arch .....		81.70	<b>1350.89</b>	20	20
92186	Construction absent condyle and ascending ramus .....		49.02	<b>774.40</b>	10	10
92188	Combined LeFort I and LeFort III osteotomy in hemifacial microsomia.....		81.70	<b>1469.09</b>	20	20
92200	Mandibular condylotomy .....		32.68	<b>197.31</b>	5	5
92202	Coronoidotomy .....		32.68	<b>197.31</b>	5	5
92204	Coronoidectomy .....		32.68	<b>295.94</b>	5	5
Reconstruction mandible with bone grafts and/or plate or prosthesis						
92210	- unilateral - partial.....		32.68	<b>394.62</b>	10	10
92212	- complete .....		32.68	<b>789.13</b>	10	10
92214	- bilateral - partial.....		32.68	<b>789.13</b>	10	10
92216	- complete .....		32.68	<b>985.85</b>	10	10
Oral vestibuloplasty						
92218	- with secondary epithelization .....		32.68	<b>197.31</b>	5	5
92220	- with skin graft .....		32.68	<b>295.94</b>	5	5
Temporomandibular ankylosis						
92222	- excision bone or fibrous block.....		24.51	<b>444.31</b>	6	6
92224	- with insertion of prosthetic device or muscle flap .....		32.68	<b>493.25</b>	8	8
92226	- with construction of condyle and ascending ramus....		32.68	<b>641.67</b>	10	10

**SURGICAL PROCEDURES****OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

<b>Code</b>	<b>G.P.</b>	<b>Assist</b>	<b>Spec.</b>	<b>Spec. Anaes.</b>	<b>G.P. Anaes.</b>
<b>SKULL AND MANDIBLE (Cont'd)</b>					
<b>Orthognathic Surgery (Cont'd)</b>					
Onlay bone grafts to face when not part of standard osteotomy for reconstruction					
92230				<b>345.68</b>	
92232				<b>444.31</b>	
92234				<b>345.68</b>	
92236				<b>444.31</b>	
92238				<b>295.94</b>	
92240				<b>394.62</b>	
92242				<b>394.62</b>	
92244				<b>493.25</b>	
92246				<b>394.62</b>	
92248				<b>493.25</b>	
Application of dental arch bars, or splint, for facial osteotomy (IOP)					
92260		32.68	<b>128.10</b>	4	4
92262		32.68	<b>197.31</b>	4	4
92264		24.51	<b>148.00</b>	5	5
92266			<b>98.20</b>	4	4
<b>Orbito-cranial Surgery</b>					
Bilateral periorbital correction Treacher-Collins Syndrome					
92280		81.70	<b>1604.07</b>	20	20
92282		81.70	<b>2044.08</b>	25	25
92284			<b>295.94</b>	4	4
92286			<b>394.62</b>	4	4
- when in conjunction with coronal approach for main operation					
92288			<b>172.41</b>		
92290			<b>285.77</b>		
92292		98.04	<b>1962.02</b>	25	25
92294		98.04	<b>2494.95</b>	25	25
92296		98.04	<b>2248.87</b>	25	25
92298		98.04	<b>2820.84</b>	25	25
Upper LeFort III advancement without occlusal change					
92300		49.02	<b>897.98</b>	10	10
92302		98.04	<b>1390.90</b>	25	25
Forehead advancement (bone grafts not included)					
92304		98.04	<b>1143.95</b>	25	25
92306		98.04	<b>1390.90</b>	25	25
92308		81.70	<b>1469.09</b>	20	20
92310		98.04	<b>2001.97</b>	25	25
92320		24.51	<b>398.71</b>	6	6
92322			<b>148.00</b>		
92324		24.51	<b>197.31</b>	6	6
92326			<b>97.66</b>		

**SURGICAL PROCEDURES**

**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>SKULL AND MANDIBLE (Cont'd)</b>					
<b>Orbito-cranial Surgery (Cont'd)</b>					
Hypertelorism correction					
92328			98.04	<b>2248.87</b>	25 25
92330			98.04	<b>1878.55</b>	25 25
92332			81.70	<b>1183.10</b>	20 20
92334			81.70	<b>1553.42</b>	20 20
92336			98.04	<b>1878.55</b>	25 25
92338			81.70	<b>1430.91</b>	20 20
Late correction traumatic enophthalmos - total periorbital stripping and bone grafts					
92340			98.04	<b>1923.83</b>	25 25
92342			81.70	<b>1390.90</b>	20 20
Harvesting of bone graft when not included					
92350				<b>96.15</b>	
92352				<b>148.00</b>	
92354				<b>74.00</b>	
92356				<b>221.99</b>	
92358				<b>148.00</b>	
92360				<b>197.31</b>	
<b>Surgery for Correction of Down's Syndrome Facial Stigmata</b>					
Augmentation of zygoma (bilateral)					
92370				<b>173.86</b>	
92372				<b>217.48</b>	
Augmentation of chin					
92380				<b>144.98</b>	
92382				<b>178.86</b>	
92384				<b>173.86</b>	
<b>Reduction - Fractures</b>					
Orbit					
Open reduction rim/wall fracture					
92400			32.68	<b>399.48</b>	6 6
92402				<b>67.76</b>	
92406			32.68	<b>393.40</b>	6 6
92408			40.85	<b>459.10</b>	6 6
Nasal bones (including septum)					
92410		<b>88.33</b>		<b>98.14</b>	4 4
92412				<b>246.62</b>	5 5
92414				<b>62.70</b>	
92415				<b>39.26</b>	
92426			40.85	<b>451.12</b>	8 8
92428			40.85	<b>522.72</b>	10 10

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>SKULL AND MANDIBLE (Cont'd)</b>					
<b>Reduction - Fractures (Cont'd)</b>					
Mandible					
92430				<b>246.62</b>	5 5
92432				<b>449.25</b>	5 5
		32.68			
92434				<b>83.89</b>	
92436					
		IC		IC	IC
92438					5 5
92439				<b>98.65</b>	
Maxilla					
92440				<b>246.62</b>	
92442				<b>142.94</b>	5 5
		32.68			
92444				<b>386.77</b>	6 6
		40.85			
92446				<b>96.48</b>	
92447				<b>98.65</b>	
Temporo-mandibular joint					
92450				<b>49.37</b>	4 4
92452				<b>246.62</b>	5 5
		40.85			

## SURGICAL PROCEDURES

## OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>SPINE</b>						
Arthrodesis						
92470	Anterior or posterior fusion of 1 level.....		57.19	<b>440.46</b>	10	10
92472	Fusion of C1-2.....		65.36	<b>621.16</b>	10	10
92474	Each additional level (max. of 2) ..... add			<b>95.55</b>		
Fusion with other procedure(s) - by same surgeon						
92476	- 1 level..... add			<b>272.11</b>		
92478	- multiple levels ..... add			<b>346.46</b>		
92480	- anterior cervical interbody fusion, per level..... add			<b>90.92</b>		
Fusion by different surgeon						
92482	- 1 level.....			<b>347.99</b>		
92484	- multiple levels.....			<b>409.29</b>		
92486	- anterior cervical interbody fusion, per level..... add			<b>134.51</b>		
92488	Repeat fusion..... add			<b>225.74</b>		
92490	With instrumentation..... add			<b>154.49</b>		
<b>Biopsy</b>						
92500	Bone- needle (IOP).....		32.68	<b>162.03</b>	4	4
92502	- open - posterior approach.....		32.68	<b>271.12</b>	7	7
92504	- anterior approach.....		49.02	<b>346.76</b>	8	8
92506	Soft tissue - open (IOP).....			<b>108.73</b>	4	4
<b>Decompression - Anterior, Anterolateral or Posterolateral</b>						
92510	Simple anterior cervical discectomy.....		65.36	<b>445.65</b>	10	10
92512	Simple anterior lumbar discectomy.....		49.02	<b>548.43</b>	10	10
92514	Anterior cervical spinal cord or nerve root decompression, including removal of disc or vertebral body, single disc level.....		65.36	<b>676.21</b>	10	10
92516	Anterior decompression with instrumentation.....		73.53	<b>1618.96</b>	13	13
92518	Anterolateral or posterolateral decompression, lumbar or thoracic spine, single disc level.....		73.53	<b>1210.41</b>	13	13
92520	- each additional disc level decompressed - to 92510, 92512, 92514, 92518..... add			<b>291.90</b>		
<b>Decompression - Posterior</b>						
92540	Cervical hemilaminectomy for disc disease, with or without foraminotomy.....		49.02	<b>639.84</b>	10	10
92542	Lumbar hemilaminectomy for disc disease including removal of soft disc or osteophyte.....		49.02	<b>467.42</b>	8	8
92544	- multiple levels, to 92540, 92542..... add			<b>80.53</b>		
92546	- bilateral, to 92540, 92542..... add			<b>86.71</b>		
92548	Posterior laminectomy 1 or 2 levels, cervical, thoracic, lumbar.....		49.02	<b>676.21</b>	9	9

## SURGICAL PROCEDURES

## OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>SPINE (Cont'd)</b>						
<b>Decompression - Posterior (Cont'd)</b>						
92550	Repeat posterior exploration or reopening of posterior exploration, more than six months after original procedure, includes foraminotomy, discectomy or neurolysis .....		65.36	<b>729.27</b>	10	10
92552	- laminectomy extending over 3 or more laminae, to 92548, 92550 .....			<b>175.02</b>		
92554	- foraminotomy, to 92542, 92548 and 92550 per foramen decompressed.....			<b>89.80</b>		
92556	- opening of dura (associated with any decompressive procedure) .....			<b>189.68</b>		
92558	- spinal duroplasty (applies to any spinal procedure) .....			<b>288.66</b>		
<b>Incision and Drainage (Osteomyelitis)</b>						
92570	Bone - incision and drainage only.....		32.68	<b>337.55</b>	4	4
Sequestrectomy						
92572	- anterior.....		57.19	<b>704.28</b>	10	10
92574	- posterior.....		32.68	<b>401.99</b>	4	4
Saucerization with bone grafting						
92576	- anterior.....		49.02	<b>867.43</b>	10	10
92578	- posterior.....		32.68	<b>490.30</b>	5	5
92580	Soft tissue.....			<b>118.50</b>		
<b>Examination/Manipulation</b>						
92590	Manipulation under sedation/anaesthesia (IOP).....			<b>43.36</b>	4	4
<b>Excision - Bone</b>						
92600	Spinous process.....		32.68	<b>271.37</b>	4	4
92602	Lamina or transverse process .....		49.02	<b>433.16</b>	8	8
92604	Part of body or pedicle.....		49.02	<b>649.99</b>	8	8
92606	Total body (includes replacement).....		73.53	<b>1082.65</b>	13	13
<b>Excision - Muscle/Soft Tissue</b>						
92610	Tumours - simple .....		49.02	<b>239.57</b>	8	8
92612	- radical resection .....		73.53	<b>591.06</b>	13	13
<b>Reconstruction - Osteotomy (includes fixation/fusion)</b>						
92620	Anterior - via chest .....		73.53	<b>811.28</b>	13	13
92622	- via abdomen.....		73.53	<b>867.43</b>	9	9
92624	- via chest and abdomen.....		73.53	<b>976.52</b>	13	13
92626	Posterior .....		73.53	<b>767.61</b>	9	9
92628	- with rib or transverse release .....			<b>137.92</b>		
92630	Circumferential .....		73.53	<b>1300.22</b>	9	9
92632	Cervical .....		81.70	<b>1138.92</b>	12	12



**SURGICAL PROCEDURES**

**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>SPINE (Cont'd)</b>						
<b>Instrumentation - Deformities</b>						
Anterior - includes fusion/disectomy						
92640	- via chest or abdomen .....		73.53	<b>1422.79</b>	17	17
92642	- via chest and abdomen.....		73.53	<b>1569.54</b>	17	17
92644	Posterior (Harrington) - with or without fusion (92648, 92650, 92652 may be billed as appropriate .....		65.36	<b>863.22</b>	12	12
92646	Readjustment of instrumentation .....			<b>162.03</b>	4	4
92648	- Harrington instrumentation to sacrum or pelvis (payable in addition to 92644 or 92646 only, ..add			<b>86.71</b>		
92650	- Harrington instrumentation, for each level over 6 (payable in addition to 92644 or 92646 only).....add			<b>21.03</b>		
92652	- with posterior osteotomy (payable with 92650 only) .....add			<b>164.63</b>		
92654	Segmental procedure - with fusion.....		65.36	<b>1307.38</b>	12	12
92656	- segmental instrumentation to pelvis, add to 92654.....			<b>172.42</b>		
92658	- segmental instrumentation, for each level over 6 add			<b>34.07</b>		
92660	Removal of - anterior instrumentation.....		65.36	<b>324.06</b>	8	8
92662	- posterior instrumentation .....		65.36	<b>292.89</b>	8	8
Revision of entire instrumentation						
92664	- with fusion.....		65.36	<b>1354.39</b>	12	12
92666	- without fusion.....		65.36	<b>1082.65</b>	12	12
92682	Removal of electrodes.....		65.36	<b>285.11</b>	8	8
92684	Muscle stripping spine prior to surgery.....		49.02	<b>216.02</b>	8	8
92686	Halo traction prior to surgery (complete care) .....		24.51	<b>325.68</b>	4	4
<b>NOTE: 92684 and 92686 allow full benefit if followed by surgery for correction of scoliosis in same hospitalization.</b>						
Anterior release including Halo traction						
92690	- via chest or abdomen .....		73.53	<b>610.77</b>	13	13
92692	- via chest and abdomen.....		73.53	<b>758.34</b>	13	13
92694	Localizer cast .....			<b>148.55</b>	4	4
<b>Reduction - Fractures or Fracture Dislocations</b>						
Fracture of spine without procedure..... VF VF						
92702	Skull calipers (IOP).....			<b>56.04</b>		
92704	Halo traction (IOP).....			<b>89.80</b>		
92706	Reapplication of Halo traction (IOP).....			<b>56.04</b>		
92708	- counter traction pins or vest..... add			<b>119.98</b>		
92710	Closed reduction .....		40.85	<b>226.48</b>	5	5

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>SPINE (Cont'd)</b>					
<b>Reduction - Fractures or Fracture Dislocations (Cont'd)</b>					
Open reduction					
92712		40.85	<b>347.99</b>	10	10
92714		57.19	<b>409.29</b>	10	10
92716			<b>174.03</b>		
92718			<b>347.99</b>		
92720			<b>272.11</b>		
92722			<b>346.46</b>		
92724			<b>347.99</b>		
92726			<b>409.29</b>		
92728			<b>154.49</b>		
92729			<b>90.59</b>		

## SURGICAL PROCEDURES

## OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>PELVIS AND HIP</b>						
<b>Amputation</b>						
92740	Hemipelvectomy - hindquarter .....		81.70	<b>774.99</b>	15	15
92742	Hip disarticulation .....		81.70	<b>476.86</b>	10	10
<b>Arthrodesis</b>						
92750	Sacro-iliac joint.....		40.85	<b>384.83</b>	5	5
92752	Symphysis pubis .....		40.85	<b>376.66</b>	6	6
92754	Hip.....		40.85	<b>684.69</b>	8	8
<b>Arthroplasty</b>						
92760	Unipolar.....		49.02	<b>577.48</b>	8	8
92762	Bipolar.....		65.36	<b>679.21</b>	8	8
92764	Total hip replacement with take down of fusion.....		65.36	<b>948.58</b>	10	10
92766	Revision total arthroplasty hip .....		65.36	<b>1422.88</b>	10	10
92768	Total hip arthroplasty.....		65.36	<b>825.59</b>	8	8
92770	- bone graft to acetabulum..... add			<b>98.20</b>		
92772	- acetabular reconstruction (extensive, including bone grafts)..... add			<b>188.97</b>		
92774	Reattachment of greater trochanter (late) .....			<b>282.22</b>	8	8
92776	Removal only - non-cemented .....		24.51	<b>435.38</b>	8	8
92778	- cemented .....		24.51	<b>542.83</b>	8	8
<b>Arthroscopy</b>						
92790	Hip joint, sole procedure (IOP).....			<b>178.86</b>	4	4
92792	- preceding surgery, same surgeon..... add			<b>134.26</b>		
<b>Arthrotomy</b>						
92800	Sacro-iliac joint.....		40.85	<b>282.22</b>	6	6
92802	Hip - with removal of loose body .....		40.85	<b>293.52</b>	6	6
92810	Hip - infant or child, under general anaesthesia .....		24.51	<b>61.84</b>	4	4
<b>Biopsy</b>						
92820	Bone- punch needle (IOP) .....			<b>70.45</b>		
92822	- under general anaesthetic (IOP).....			<b>70.45</b>	5	5
92824	- open (IOP).....		32.68	<b>140.90</b>	4	4
92826	Joint - via arthroscope .....			<b>10.65</b>		
92828	- open .....		40.85	<b>293.52</b>	6	6
92830	Soft tissue - open .....			<b>94.54</b>	4	4
<b>Denervation/Decompression</b>						
92840	Decompression of lateral femoral cutaneous nerve .....		32.68	<b>146.33</b>	4	4
92842	Exploration and/or decompression of sciatic nerve .....		49.02	<b>410.11</b>	6	6
92844	Exploration and/or decompression and/or transposition and/or neurolysis of major nerve .....		32.68	<b>243.93</b>	4	4
92846	Denervation of hip .....		32.68	<b>376.66</b>	5	5

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>PELVIS AND HIP (Cont'd)</b>						
<b>Incision and Drainage</b>						
92850	Bone, incision and drainage.....		24.51	<b>282.22</b>	4	4
92852	Sequestrectomy.....		32.68	<b>368.91</b>	4	4
92854	Saucerization and bone graft.....		32.68	<b>610.59</b>	5	5
92856	Bursae/soft tissue (IOP).....			<b>94.54</b>	4	4
92858	Joint.....		40.85	<b>293.52</b>	6	6
<b>Examination/Manipulation</b>						
92870	Manipulation - under general anaesthetic (IOP) .....			<b>37.70</b>	4	4
<b>Excision - Bone</b>						
92880	Simple cyst, etc. ....		32.68	<b>329.66</b>	4	4
92882	Major resection tumour.....		32.68	<b>471.52</b>	6	6
92884	Radical resection tumour.....		65.36	<b>754.28</b>	8	8
92886	Coccyx.....		32.68	<b>202.96</b>	4	4
92888	Head and neck, femur.....		32.68	<b>440.33</b>	6	6
<b>Excision - Muscle</b>						
92900	Simple.....		24.51	<b>187.84</b>	4	4
92902	Complex.....		32.68	<b>471.52</b>	6	6
92904	Myositis.....		32.68	<b>281.79</b>	5	5
<b>Excision - Joint</b>						
92910	Synovectomy/debridement .....		40.85	<b>457.97</b>	5	5
<b>Excision - Bursae</b>						
92920	GT trochanteric/ischial .....		24.51	<b>195.53</b>	4	4
<b>Reconstruction - Pseudoarthrosis</b>						
92930	Pelvis .....		65.36	<b>565.42</b>	10	10
92932	Hip .....		49.02	<b>464.74</b>	6	6
<b>Reconstruction - Osteotomy</b>						
92940	Pelvis - infant.....			<b>388.38</b>	8	8
92942	- other .....		65.36	<b>565.42</b>	8	8
92944	Hip .....		40.85	<b>524.76</b>	7	7
<b>Reconstruction - Muscle/Tendon</b>						
92950	Muscle release.....		40.85	<b>306.21</b>	5	5
92952	Closed adductors - tenotomy (IOP) .....			<b>47.43</b>	4	4
92954	Open adductors - tenotomy (IOP).....			<b>94.54</b>	4	4
92956	Iliopsoas - tenotomy.....		40.85	<b>259.21</b>	5	5
<b>Reconstruction - Tendon Transfer</b>						
92970	Iliopsoas.....		40.85	<b>506.26</b>	6	6
92972	Abductor .....		40.85	<b>330.09</b>	6	6

**SURGICAL PROCEDURES**

**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>PELVIS AND HIP (Cont'd)</b>						
<b>Reduction - Fractures</b>						
	Coccyx - no reduction .....	VF		VF		
92982	- excision .....		32.68	<b>202.96</b>	4	4
	Pelvic ring - no reduction .....	VF		VF		
92986	- closed reduction .....		24.51	<b>431.73</b>	4	4
92988	- open reduction .....		49.02	<b>680.30</b>	8	8
92989	- extensive debridement of compound fracture .....			<b>172.69</b>		
	..... add					
	Sacrum - no reduction .....	VF		VF		
	Femoral neck trochanteric, subtrochanteric					
	- no reduction .....	VF		VF		
92994	- closed reduction/traction .....		24.51	<b>415.48</b>	4	4
92996	- open reduction - pin only .....		49.02	<b>432.34</b>	8	8
92998	- pin and plate .....		49.02	<b>487.56</b>	8	8
93000	- primary prosthesis .....		49.02	<b>540.39</b>	8	8
93002	- delayed/staged graft .....		49.02	<b>281.79</b>	8	8
93003	- extensive debridement of compound fracture .....			<b>166.19</b>		
	Slipped epiphysis					
93004	- closed reduction/traction .....		49.02	<b>376.66</b>	8	8
93006	- closed reduction/internal fixation .....		49.02	<b>376.66</b>	8	8
93008	- open reduction/fixation .....		49.02	<b>565.42</b>	8	8
93009	- extensive debridement of compound fracture .....			<b>150.66</b>		
	..... add					
<b>Reduction - Dislocations</b>						
	Acetabulum - no reduction	VF		VF		
93022	- open reduction - lips .....		57.19	<b>596.18</b>	8	8
93024	- 1 pillar .....		32.68	<b>967.90</b>	10	10
93026	- 2 pillars .....		65.36	<b>1451.45</b>	12	12
93028	Hip - closed reduction .....			<b>260.61</b>	4	4
93030	- open reduction .....		57.19	<b>395.16</b>	7	7
93032	- late .....		57.19	<b>754.28</b>	10	10
93033	- extensive debridement of compound fracture .....			<b>104.24</b>		
	Sacro-iliac					
93034	- closed, traction, spica, etc. ....			<b>417.74</b>	5	5
93036	- open reduction .....		40.85	<b>577.14</b>	5	5
93037	- extensive debridement of compound fracture .....			<b>167.10</b>		
	Sacro-coccygeal					
	- closed reduction .....	VF		VF		
93040	- open, removal of coccyx .....		40.85	<b>187.84</b>	5	5
93041	- extensive debridement of compound fracture .....			<b>6.64</b>		
	Congenital hip					
93042	- closed reduction (includes tenotomy and cast) .....			<b>185.32</b>	4	4
93044	- repeat (includes cast) .....			<b>128.47</b>	4	4
93046	- open reduction (includes tenotomy and arthrotomy) ..		57.19	<b>459.58</b>	7	7
93048	Application Pavlik Harness or CDH splint .....			<b>23.45</b>		

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>FEMUR</b>						
<b>Amputation</b>						
93060	Gritti-Stokes or Callander.....		40.85	<b>379.64</b>	5	5
93062	Through femur .....		40.85	<b>348.30</b>	5	5
<b>Biopsy (IOP)</b>						
93070	Bone- core, punch .....			<b>37.70</b>	4	4
93072	- x-ray control/general anaesthetic .....			<b>94.54</b>	4	4
93074	- open .....		32.68	<b>187.84</b>	4	4
93076	Soft tissue - open.....			<b>94.54</b>	4	4
93078	Injection into bone cysts.....			<b>113.79</b>		
<b>Incision and Drainage (Osteomyelitis)</b>						
93090	Incision and drainage, bone.....		24.51	<b>317.07</b>	4	4
93092	Sequestrectomy .....		24.51	<b>384.29</b>	4	4
93094	Saucerization and graft.....		40.85	<b>603.38</b>	6	6
93096	Soft tissue .....			<b>103.05</b>	4	4
<b>Excision - Bone</b>						
93100	Simple cyst/exostosis.....		32.68	<b>219.47</b>	4	4
93102	Bone tumour - simple .....		32.68	<b>471.52</b>	6	6
93104	- with reconstruction/graft.....		65.36	<b>754.28</b>	8	8
<b>Excision - Muscle</b>						
93110	Simple.....		24.51	<b>187.84</b>	4	4
93112	Complex.....		32.68	<b>471.52</b>	6	6
<b>Reconstruction - Pseudoarthrosis</b>						
93114	Reconstruction - pseudoarthrosis .....		49.02	<b>464.74</b>	6	6
<b>Reconstruction - Fascial</b>						
93120	Simple.....		24.51	<b>187.84</b>	4	4
93122	Complex with or without synthetic graft or rotation flap.....		49.02	<b>392.04</b>	5	5
<b>Reconstruction - Osteotomy</b>						
93130	Femoral shaft.....		32.68	<b>518.52</b>	5	5
93132	Supracondylar.....		49.02	<b>376.66</b>	6	6
<b>Reconstruction - Leg Length Operations</b>						
93140	Femoral shortening - all types.....		32.68	<b>467.86</b>	4	4
93142	Femoral lengthening - all types.....		32.68	<b>527.45</b>	4	4
93144	Femoral epiphysiodesis .....		32.68	<b>293.09</b>	5	5
93146	Tibial and femoral epiphysiodesis.....		32.68	<b>415.48</b>	5	5
93148	Femoral stapling .....		32.68	<b>304.86</b>	4	4
93150	Tibial and femoral stapling .....		32.68	<b>376.66</b>	5	5

**SURGICAL PROCEDURES**

**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>FEMUR (Cont'd)</b>						
<b>Reconstruction - Muscle/Tendons</b>						
93160	Quadriceps repair - simple .....		24.51	<b>221.51</b>	4	4
93162	- reconstructive.....		24.51	<b>376.66</b>	4	4
93164	Quadricepsplasty - all types .....		32.68	<b>371.28</b>	5	5
93166	Ilio-tibial band.....		24.51	<b>183.81</b>	4	4
93168	Closed release of ilio-tibial band (IOP) .....			<b>47.43</b>	4	4
93170	Tenotomy of hamstrings - single.....		24.51	<b>163.91</b>	4	4
93172	- multiple.....		24.51	<b>188.11</b>	4	4
	Lengthening of hamstrings					
93174	- single .....		24.51	<b>217.91</b>	4	4
93176	- each additional..... add			<b>74.64</b>		
	Tendon or muscle transfer					
93178	- single .....		24.51	<b>298.73</b>	5	5
93180	- each additional (max. of 1) .....			<b>84.86</b>		
93182	Excision of myositis.....		32.68	<b>281.79</b>	5	5
<b>Reduction - Fractures</b>						
	Femoral shaft/supracondylar					
	- no reduction, cast .....	VF		VF		
	- closed reduction - traction					
93202	- infant or child.....		24.51	<b>251.09</b>	4	4
93204	- adult or adolescent.....		24.51	<b>396.55</b>	4	4
93206	- closed reduction, cast .....		24.51	<b>252.00</b>	4	4
93208	- open reduction .....		49.02	<b>493.80</b>	8	8
93209	- extensive debridement of compound fracture, infant or child..... add			<b>100.43</b>		
93210	- extensive debridement of compound fracture, adult or adolescent..... add			<b>158.62</b>		

## SURGICAL PROCEDURES

## OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>KNEE</b>						
<b>Amputation</b>						
93220	Through knee - disarticulation.....		40.85	<b>296.74</b>	5	5
<b>Arthrodesis</b>						
93230	Knee .....		24.51	<b>391.55</b>	5	5
<b>Arthroplasty</b>						
93240	Patellar arthroplasty.....		24.51	<b>235.76</b>	5	5
93242	Hemi-arthroplasty - single component .....		49.02	<b>342.35</b>	6	6
93244	- double component.....		49.02	<b>435.38</b>	6	6
93246	Total replacement/both compartments.....		65.36	<b>612.30</b>	8	8
93248	Total knee replacement with take down of fusion .....		65.36	<b>815.70</b>	8	8
93250	Revision total arthroplasty knee.....		65.36	<b>1223.54</b>	8	8
93252	With associated patellar replacement or patelloplasty .add			<b>91.64</b>		
93254	Removal of hemi-arthroplasty - without replacement.....		32.68	<b>235.76</b>	5	5
93256	Removal of total arthroplasty - without replacement.....		32.68	<b>358.59</b>	5	5
93258	Revision of arthroplasty .....			<b>169.94</b>		
<b>Arthroscopy</b>						
93270	Diagnostic arthroscopy (sole procedure) .....			<b>192.37</b>	4	4
93272	Synovial biopsy.....			<b>42.81</b>		
93274	Trimming of plica, tissue, meniscus .....			<b>62.27</b>		
93276	Removal of loose body, screw .....			<b>187.84</b>		
93278	Resection of plica .....			<b>86.42</b>		
93280	Lateral release .....			<b>140.41</b>		
93282	Synovectomy - anterior - 1 compartment.....			<b>127.99</b>		
93284	- anterior - more than 1 compartment.....			<b>256.41</b>		
93286	- total, anterior and posterior.....			<b>469.58</b>		
93288	Drilling of defect, includes removal of loose body .....			<b>245.55</b>		
93290	Pinning of osteochondral fragment .....			<b>245.55</b>		
93292	Debridement - 1 compartment.....			<b>284.29</b>		
93294	- more than 1 compartment.....			<b>377.86</b>		
93296	With abrasion arthroplasty .....			<b>281.79</b>		
93298	Meniscectomy.....			<b>337.70</b>		
93300	Repair medial or lateral meniscus.....			<b>320.17</b>		
93302	Arthroscopy in association with surgery including 93272 to 93300 - same surgeon.....add			<b>144.40</b>		
<b>Arthrotomy</b>						
93320	Knee - with or without removal of loose body .....		24.51	<b>202.31</b>	4	4
93322	Osteochondritis dissecans with drilling and/or internal fixation .....		24.51	<b>260.18</b>	4	4
<b>Biopsy</b>						
93330	Bone/joint - needle (IOP).....			<b>94.54</b>	4	4
93332	- open (IOP).....		32.68	<b>187.84</b>	4	4
93334	- via arthroscope.....			<b>10.65</b>		
93336	Soft tissue - open (IOP).....			<b>94.54</b>	4	4



## SURGICAL PROCEDURES

## OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>KNEE (Cont'd)</b>						
<b>Denervation/Decompression</b>						
93340	Denervation - of knee .....		24.51	<b>250.60</b>	4	4
93342	- of gastrocnemius.....		32.68	<b>243.93</b>	4	4
<b>Incision and Drainage</b>						
93350	Soft tissue (IOP).....	<b>85.09</b>		<b>94.54</b>	4	4
93352	Joint .....		24.51	<b>187.84</b>	4	4
<b>Examination/Manipulation</b>						
93360	Manipulation - under general anaesthetic (IOP).....			<b>23.02</b>	4	4
<b>Excision</b>						
93370	Baker's cyst - simple.....		24.51	<b>144.50</b>	4	4
93372	- extensive .....		32.68	<b>256.95</b>	6	6
93374	Cysts of meniscus .....		24.51	<b>122.83</b>	4	4
93376	Meniscectomy .....		24.51	<b>234.36</b>	4	4
93378	Debridement of joint without synovectomy .....		24.51	<b>282.71</b>	4	4
93380	Synovectomy.....		24.51	<b>418.60</b>	5	5
93382	Pre-patellar bursae.....		24.51	<b>145.20</b>	4	4
93384	Patella - to include fascial repair .....		24.51	<b>269.16</b>	4	4
93386	Exostosis/cyst patella.....		24.51	<b>122.83</b>	4	4
<b>Reconstruction - Meniscus</b>						
93390	Suturing of medial or lateral meniscus .....		24.51	<b>235.76</b>	5	5
<b>Reconstruction - Muscles/Tendons</b>						
93400	Tenoplasty - 1 .....		24.51	<b>140.90</b>	4	4
93402	- each additional..... add			<b>74.64</b>		
Suture of patellar or quadriceps tendon						
93404	- early .....		24.51	<b>221.51</b>	4	4
93406	- late .....		24.51	<b>376.66</b>	4	4
Transplant of tendon						
93408	- single.....		24.51	<b>298.73</b>	5	5
93410	- each additional (max. of 1)..... add			<b>84.86</b>		
93416	Tenotomy - open - 1 .....		24.51	<b>225.60</b>	4	4
93418	- multiple .....		24.51	<b>246.62</b>	4	4
93420	Release patellar retinaculum .....		40.85	<b>157.14</b>	5	5
<b>Reconstruction - Ligaments</b>						
93430	Simple - 1 .....		24.51	<b>351.81</b>	4	4
93432	Extensive/multiple (including synthetics).....		32.68	<b>504.00</b>	6	6
93434	Synthetic anterior/posterior cruciate .....		49.02	<b>480.02</b>	6	6
93436	Removal of synthetics .....		32.68	<b>207.74</b>	4	4

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>KNEE (Cont'd)</b>						
<b>Reduction - Fractures</b>						
93450	Patella - no reduction.....			<b>65.72</b>		
93452	- open reduction/excision with/without repair .....		32.68	<b>267.81</b>	4	4
93453	- extensive debridement of compound fracture .....add			<b>37.82</b>		
93454	Osteochondral fracture - open reduction.....		32.68	<b>244.58</b>	5	5
<b>Reduction - Dislocations</b>						
93460	Knee - closed reduction .....			<b>202.10</b>	4	4
93462	- open reduction.....		40.85	<b>300.29</b>	5	5
Patella						
- closed reduction						
93464	- without anaesthetic.....	<b>54.41</b>		<b>60.45</b>		
93466	- with anaesthetic.....			<b>94.54</b>	4	4
93468	- open reduction - early .....			<b>282.22</b>	5	5
93470	- late .....		32.68	<b>471.52</b>	6	6
93472	- repair recurrent dislocation, includes inspection of joint .....		32.68	<b>382.68</b>	5	5
93474	Congenital dislocation - knee (open) .....		32.68	<b>471.52</b>	6	6

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>FIBULA AND TIBIA</b>					
<b>Amputation</b>					
93490		40.85	<b>348.30</b>	5	5
<b>Biopsy</b>					
93500			<b>94.54</b>	4	4
93502		32.68	<b>187.84</b>	4	4
93504			<b>94.54</b>	4	4
93506			<b>113.79</b>		
<b>Decompression/Denervation</b>					
93510		24.51	<b>312.55</b>	4	4
93512			<b>94.54</b>		
93514			<b>47.73</b>		
93518	VF		VF		
		32.68	<b>160.31</b>	4	4
<b>Incision and Drainage (Osteomyelitis)</b>					
93530		24.51	<b>299.86</b>	4	4
93532		24.51	<b>320.62</b>	4	4
93534		24.51	<b>399.89</b>	4	4
93536			<b>94.54</b>	4	4
<b>Excision</b>					
93540		24.51	<b>195.53</b>	4	4
93542		24.51	<b>187.84</b>	4	4
93544		32.68	<b>281.36</b>	4	4
93546		40.85	<b>659.20</b>	6	6
93548		40.85	<b>374.83</b>	6	6
93550		24.51	<b>187.84</b>	4	4
93552		32.68	<b>513.96</b>	6	6
<b>Reconstruction - Pseudoarthrosis</b>					
93560		32.68	<b>338.69</b>	5	5
93562		32.68	<b>331.91</b>	6	6
93564		32.68	<b>471.52</b>	6	6
<b>Reconstruction - Osteotomy</b>					
93570		24.51	<b>366.28</b>	4	4
93572		32.68	<b>382.68</b>	6	6
<b>Reconstruction - Leg Length Operations</b>					
93580		32.68	<b>457.97</b>	4	4
93582		32.68	<b>376.66</b>	4	4
93584		32.68	<b>415.48</b>	5	5
93586		32.68	<b>313.41</b>	5	5
93588		32.68	<b>187.84</b>	4	4
93590		32.68	<b>235.76</b>	4	4
93592		32.68	<b>376.66</b>	5	5

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>FIBULA AND TIBIA (Cont'd)</b>						
<b>Reduction - Fractures</b>						
Tibia with or without fibula						
93610	- no reduction, rigid immobilization .....			<b>113.15</b>		
93612	- closed reduction .....		24.51	<b>175.21</b>	4	4
93614	- open reduction - shaft .....		32.68	<b>407.25</b>	5	5
93616	- medial or lateral tibial plateau .....		32.68	<b>394.45</b>	5	5
93618	- both tibial plateaus, same knee.....		32.68	<b>591.67</b>	5	5
93619	- extensive debridement of compound fracture .....add			<b>70.08</b>		
93620	Fibula - no reduction, rigid immobilization .....	<b>59.15</b>		<b>65.72</b>		
93622	- closed reduction .....			<b>97.98</b>	4	4
93624	- open reduction.....		32.68	<b>223.82</b>	4	4
93625	- extensive debridement of compound fracture add			<b>39.19</b>		

## SURGICAL PROCEDURES

## OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>FOOT AND ANKLE</b>						
<b>Amputation</b>						
93640	Metatarsal/phalanx disarticulation .....		32.68	<b>151.76</b>	4	4
93642	- each additional..... add			<b>45.82</b>		
93644	Ray (single) .....		32.68	<b>234.38</b>	4	4
93646	Symes .....		40.85	<b>302.70</b>	5	5
93648	Transmetatarsal/transarsal.....		32.68	<b>270.22</b>	4	4
93650	Terminal Symes .....		40.85	<b>200.68</b>	5	5
<b>Arthrodesis</b>						
93660	Ankle .....		24.51	<b>379.35</b>	4	4
93662	Interphalangeal .....		24.51	<b>154.02</b>	4	4
93664	- each additional..... add			<b>40.66</b>		
93666	Metatarsophalangeal.....		24.51	<b>262.00</b>	4	4
93668	Midtarsal/subtarsal .....		24.51	<b>342.78</b>	4	4
93670	Triple .....		24.51	<b>376.66</b>	5	5
93672	Pan-talar - 1 stage.....		24.51	<b>609.73</b>	6	6
<b>Arthroplasty</b>						
93680	Ankle - total replacement.....		49.02	<b>415.05</b>	6	6
93682	Revision total arthroplasty ankle .....		49.02	<b>549.18</b>	6	6
93684	Removal of prosthesis without replacement.....		24.51	<b>187.84</b>	6	6
Metatarsophalangeal interposition						
93686	- single.....		24.51	<b>140.90</b>	5	5
93688	- each additional..... add			<b>37.43</b>		
93690	Metatarsophalangeal.....		24.51	<b>281.79</b>	5	5
93700	- multiple.....		24.51	<b>376.66</b>	6	6
93702	Removal - prosthesis without replacement.....		24.51	<b>140.90</b>	4	4
93704	Revision of arthroplasty..... add			<b>124.76</b>		
<b>Arthroscopy</b>						
93710	Diagnostic arthroscopy (sole procedure).....		24.51	<b>178.86</b>	4	4
93712	Synovial biopsy .....			<b>42.81</b>		
93714	Removal of loose body, screw .....			<b>187.84</b>		
93716	Drilling of defect (includes removal of loose body) .....			<b>245.55</b>		
93718	Debridement - local.....			<b>245.55</b>		
93720	- total .....			<b>318.69</b>		
93722	Synovectomy - partial .....			<b>191.39</b>		
93724	- total .....			<b>469.58</b>		
93726	Pinning of osteochondral fragment.....			<b>245.55</b>		
93728	Arthroscopy in association with surgery including 93712 to 93726 - same surgeon .....			<b>134.26</b>		
<b>Arthrotomy</b>						
93740	Ankle - removal of loose body, etc. ....		24.51	<b>162.09</b>	4	4
93742	- with osteotomy of malleolus .....			<b>114.44</b>		
93744	Mid tarsals.....		24.51	<b>140.90</b>	4	4
93746	Metatarsal/phalangeal .....		24.51	<b>140.90</b>	4	4

## SURGICAL PROCEDURES

## OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>FOOT AND ANKLE (Cont'd)</b>						
<b>Biopsy</b>						
93760	Bone- needle - punch (IOP).....			<b>37.70</b>	4	4
93762	- punch - under general anaesthetic.....			<b>94.54</b>	4	4
93764	- open .....		32.68	<b>187.84</b>	4	4
93766	Joint - via arthroscope .....			<b>10.65</b>		
93768	- open.....			<b>163.05</b>	4	4
93770	Soft tissue - open (IOP)			<b>94.54</b>	4	4
<b>Incision and Drainage</b>						
93780	Incision and drainage - bone.....		24.51	<b>221.03</b>	4	4
93782	Sequestrectomy.....		32.68	<b>187.84</b>	4	4
93784	Saucerization and bone graft.....		32.68	<b>376.66</b>	4	4
93786	Bursae (IOP).....			<b>94.54</b>	4	4
93788	Joints .....		24.51	<b>176.67</b>	4	4
93790	Soft tissue (IOP) .....			<b>94.54</b>	4	4
<b>Examination/Manipulation (IOP)</b>						
93800	- under general anaesthetic.....			<b>23.02</b>	4	4
	Club foot, etc. - manipulation and cast/strapping					
93810	- without anaesthetic.....			<b>19.36</b>		
93812	- with anaesthetic .....			<b>37.70</b>	4	4
<b>Excision - Bone</b>						
93820	Phalanx.....		24.51	<b>123.90</b>	4	4
93822	Metatarsal head.....		24.51	<b>170.26</b>	4	4
93824	- each additional .....			<b>40.66</b>		
93826	Accessory navicular (scaphoid) .....		24.51	<b>151.54</b>	4	4
93828	Bunion/bunionette.....		24.51	<b>146.54</b>	4	4
93830	Calcaneal spur.....		24.51	<b>135.52</b>	4	4
93832	Exostosis (dorsal, subungual).....		24.51	<b>97.77</b>	4	4
93834	Os calcis, talus.....		24.51	<b>276.42</b>	4	4
93836	Sesamoid, 1 or both.....		24.51	<b>137.78</b>	4	4
93838	Tarsal bar .....		24.51	<b>224.04</b>	4	4
93840	Tumour (foot) .....		24.51	<b>234.79</b>	4	4
<b>Excision - Joint</b>						
93850	Ankle synovectomy.....		24.51	<b>266.20</b>	4	4
	Metatarsophalangeal synovectomy					
93852	- 1 .....		24.51	<b>219.95</b>	4	4
93854	- 2 or more .....		24.51	<b>330.09</b>	4	4
<b>Excision - Soft Tissue</b>						
93860	Ganglio - simple or complex .....		24.51	<b>117.23</b>	4	4
93862	Bursa .....		24.51	<b>145.20</b>	4	4
93864	Fascia (Dupuytren's) - partial or complete .....		24.51	<b>322.66</b>	4	4
93866	Muscle - simple.....		24.51	<b>187.84</b>	4	4
93868	- complex.....		32.68	<b>471.52</b>	6	6

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>FOOT AND ANKLE (Cont'd)</b>					
<b>Reconstruction - Pseudoarthrosis</b>					
93880	Malleoli.....	24.51	<b>287.92</b>	4	4
93882	Tarsals/metatarsals/phalanx .....	24.51	<b>253.35</b>	4	4
<b>Reconstruction - Osteotomy</b>					
93890	Os calcis.....	24.51	<b>289.54</b>	4	4
93892	Metatarsals and phalanx .....	24.51	<b>140.90</b>	4	4
93894	- each additional..... add		<b>40.66</b>		
93896	Midtarsal/tarsal.....	24.51	<b>235.76</b>	4	4
93898	Shortening metatarsal - 1 .....	32.68	<b>219.47</b>	4	4
93900	- 2 or more .....	32.68	<b>265.55</b>	4	4
<b>Reconstruction - Forefoot</b>					
93910	Claw and hammer toe .....	24.51	<b>147.24</b>	4	4
93912	- each additional hammer toe .....		<b>40.66</b>		
93914	Hallux Valgus - e.g., Mayo, Keller .....	24.51	<b>211.35</b>	4	4
93916	- e.g., Joplin, McBride.....	24.51	<b>297.37</b>	4	4
93918	Major forefoot reconstruction, must include the first MP joint and a minimum of 2 other MP joints.....	24.51	<b>447.17</b>	5	5
93920	Overlapping 5th toe.....	24.51	<b>132.78</b>	4	4
<b>Reconstruction - Club Foot</b>					
93930	Posterior or medial release .....	32.68	<b>304.38</b>	4	4
93932	Posteromedial release, lateral shortening, tendon transfers and fusion.....	32.68	<b>360.85</b>	4	4
93936	Plantar fascia release.....	24.51	<b>161.01</b>	4	4
<b>Reconstruction - Ligaments</b>					
93950	Ankle - 1 .....	24.51	<b>225.81</b>	4	4
93952	- extensive/multiple .....	24.51	<b>382.57</b>	4	4
<b>Reconstruction - Tendons</b>					
93960	Exploration - tendon sheath .....	24.51	<b>122.83</b>	4	4
93962	Tenolysis - extensive release - 1 .....	24.51	<b>196.93</b>	4	4
93964	- each additional digit (max. of 2) .....		<b>84.86</b>		
93966	Tendon transfer foot and ankle - single.....	24.51	<b>246.62</b>	4	4
93968	- each additional (max. of 1)..... add		<b>92.39</b>		
93970	Tenodesis.....	24.51	<b>252.00</b>	4	4
93972	Graft .....	32.68	<b>246.62</b>	4	4
93974	- each additional..... add		<b>92.39</b>		
93976	Lengthening or shortening - 1 .....	24.51	<b>217.91</b>	4	4
93978	- each additional..... add		<b>74.64</b>		
93980	Suture extensor tendon - 1 .....	24.51	<b>122.83</b>	4	4
93982	- each additional .....		<b>46.03</b>		
93984	Suture flexor tendon - 1 .....	24.51	<b>230.28</b>	4	4
93986	- each additional .....		<b>85.83</b>		
93988	Achilles tendon repair - early .....	24.51	<b>221.51</b>	4	4
93990	- late .....	24.51	<b>376.66</b>	4	4

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>FOOT AND ANKLE (Cont'd)</b>						
<b>Reconstruction - Tendons (Cont'd)</b>						
93992	Tenotomy - open - 1 toe.....			<b>84.86</b>	4	4
93994	- more than 1 toe .....			<b>187.84</b>	4	4
93996	- closed - 1 toe (IOP) .....			<b>47.43</b>	4	4
93998	- more than 1 toe (IOP) .....			<b>94.54</b>	4	4
94000	Achilles or tibialis anterior/posterior tenotomy - open.....		24.51	<b>166.60</b>	4	4
94002	- closed .....			<b>128.69</b>	4	4
<b>Reduction - Fractures</b>						
94020	Ankle - no reduction, rigid immobilization .....	<b>59.15</b>		<b>65.72</b>		
94022	- closed reduction .....		24.51	<b>140.90</b>	4	4
94024	- open - 1 malleolus .....		32.68	<b>231.24</b>	4	4
94026	- open - multiple malleoli or ligaments .....		32.68	<b>303.52</b>	5	5
94027	- extensive debridement of compound fracture add			<b>56.36</b>		
Ankle fracture with tibial Plafond burst						
94028	- closed reduction .....		24.51	<b>235.76</b>	4	4
94030	- open reduction .....		32.68	<b>362.95</b>	6	6
94031	- extensive debridement of compound fracture ..... add			<b>94.30</b>		
94032	Metatarsus - no reduction - 1 or more.....			<b>47.43</b>		
94034	- with rigid immobilization .....	<b>59.15</b>		<b>65.72</b>		
94036	- closed reduction - 1 or more.....		24.51	<b>95.29</b>	4	4
94038	- open reduction - 1 .....		32.68	<b>172.95</b>	4	4
94040	- 2 or more.....		32.68	<b>242.54</b>	4	4
94041	- extensive debridement of compound fracture..... add			<b>38.12</b>		
94042	Os calcis - no reduction, rigid immobilization.....	<b>85.33</b>	32.68	<b>94.81</b>		
94044	- closed reduction.....			<b>157.14</b>	4	4
94046	- open reduction .....			<b>394.15</b>	4	4
94047	- extensive debridement of compound fracture ..... add			<b>62.86</b>		
Phalanx						
- no reduction, rigid immobilization						
94048	- 1 .....	<b>43.56</b>		<b>48.40</b>		
94050	- each additional .....	<b>10.55</b>		<b>11.72</b>		
94052	- closed reduction - 1 .....	<b>64.37</b>		<b>71.52</b>	4	4
94054	- each additional .....	<b>13.07</b>		<b>14.52</b>		
94056	- open reduction.....		32.68	<b>168.11</b>	4	4
94057	- extensive debridement of compound fracture..... add			<b>28.61</b>		
Tarsus excluding os calcis						
94058	- no reduction - rigid immobilization .....			<b>95.83</b>		
94060	- closed reduction .....		24.51	<b>160.31</b>	4	4
94062	- open reduction.....		32.68	<b>230.81</b>	4	4
94063	- extensive debridement of compound fracture..... add			<b>64.12</b>		
Intraarticular fracture - IP joint						
94064	- closed reduction .....			<b>76.36</b>		
94066	- open reduction .....		24.51	<b>140.90</b>	4	4
94067	- extensive debridement of compound fracture..... add			<b>30.55</b>		



**SURGICAL PROCEDURES**  
**OPERATIONS ON THE MUSCULOSKELETAL SYSTEM**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>FOOT AND ANKLE (Cont'd)</b>					
<b>Reduction - Dislocations</b>					
Ankle					
94080					
			32.68	<b>108.58</b>	4 4
94082			32.68	<b>245.23</b>	4 4
94084			32.68	<b>357.19</b>	5 5
Interphalangeal					
94086					
	<b>50.63</b>		32.68	<b>56.25</b>	4 4
94088	<b>8.61</b>			<b>9.57</b>	
					add
94090			32.68	<b>147.67</b>	4 4
Metatarsophalangeal					
94092					
				<b>55.71</b>	4 4
94094				<b>9.57</b>	
					add
94096			32.68	<b>158.97</b>	4 4
Tarsus					
94098					
				<b>143.16</b>	4 4
94100			32.68	<b>245.87</b>	4 4

## SURGICAL PROCEDURES

## OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b><u>Incision (IOP)</u></b>						
Abscess or Haematoma						
Local anaesthetic						
90100	- subcutaneous - 1 .....	18.35		20.39		
90102	- 2 .....	27.74		30.82		
90104	- 3 or more .....	37.22		41.35		
90106	- perianal .....	18.35		20.39		
90108	- ischiorectal or pilonidal .....	40.48		44.98		
90110	- palmar or plantar spaces .....	40.48		44.98		
General anaesthetic						
90112	- subcutaneous - 1 .....	40.48		44.98	4	4
90114	- 2 or more .....	66.35		73.73	4	4
90116	- perianal .....	44.11		49.03	4	4
90118	- ischiorectal or pilonidal .....	65.87		73.19	4	4
90120	- palmar or plantar spaces .....	71.80		79.77	4	4
Comedones, Acne Pustules, Millia						
90122	- ten or less .....	3.57		3.97		
90124	- eleven or more .....	12.44		13.82		
Foreign body removal - not to be claimed for the routine removal of sutures within 42 days of surgery						
90126	- local anaesthetic .....	17.13		19.03		
90128	- general anaesthetic .....	81.07	24.51	90.07	4	4
90130	- complicated .....	IC	32.68	IC	4	4
90132	Intramuscular abscess or haematoma .....	92.79		103.10	4	4
90134	Aspiration of superficial lump for cytology .....	25.80		28.66		
Biopsy(s)						
90140	- when sutures are used * .....	<b>13.87</b>		<b>15.41</b>		
90141	- when sutures are not used (maximum of 1 unit) .....	<b>13.87</b>		<b>15.41</b>		
90142	- extensive, complicated or requiring general anaesthetic, when sole procedure .....	IC	IC	IC	4	4
90144	- for malignant hyperthermia, 3 or more (fee code 90036 <u>not</u> payable in addition) .....	139.60		155.11	10	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**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b><u>Excision</u></b>					
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.					
<b><u>Excision of Benign Lesions</u></b>					
<b>Single or multiple sites, uni or bilateral (with or without biopsy)</b>					
<u>Group 1</u> - verruca, papilloma, benign keratosis, pyogenic granuloma, spider naevus, Campbell de Morgan spots (IOP)					
Removal by excision and suture					
90150				4	4
90152				4	4
90154				4	4
Paring of warts and corns without complete removal					
Removal by electrocoagulation and/or curetting and/or cryosurgery and/or laser surgery					
90156				4	4
90158				4	4
90160				4	4
<u>Groups 2</u> - naevus (IOP)					
Removal by excision and suture					
90162				4	4
90164				4	4
90166				4	4
90168		IC	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				4	4
90172				4	4
90174				4	4
Removal by electrocoagulation, and/or curetting and/or cryosurgery and/or laser surgery					
90176				4	4
90178				4	4
90180				4	4

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE INTEGUMENTARY SYSTEM**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b><u>Excision of Benign Lesions (Cont'd)</u></b>					
<b><u>Group 4 - cyst, haemangioma, lipoma (IOP)</u></b>					
<b>Face or neck</b>					
<b>Local anaesthetic</b>					
90182					
	- single lesion .....	25.92		28.80	
90184	- 2 lesions .....	38.34		42.60	
90186	- 3 or more lesions.....	52.65		58.50	
<b>General anaesthetic</b>					
90188	- single lesion .....	52.88	24.51	58.75	4 4
90190	- 2 lesions .....	79.47	24.51	88.30	4 4
90192	- 3 or more lesions.....	105.66	24.51	117.40	4 4
90194	- extensive or massive.....		24.51	IC	5 5
<b>Other Areas</b>					
<b>Local anaesthetic</b>					
90196	- single lesion .....	22.64		25.15	
90198	- 2 lesions .....	34.77		38.64	
90200	- 3 or more lesions.....	45.68		50.76	
<b>General anaesthetic</b>					
90202	- single lesion .....	45.68	24.51	50.76	4 4
90204	- 2 lesions .....	59.92	24.51	66.57	4 4
90206	- 3 or more lesions.....	98.14	24.51	109.06	4 4
90208	- extensive or massive.....	IC	24.51	IC	5 5
<b>Lipoma</b>					
90210	- 5 to 10 cm. ....	67.40	24.51	74.89	4 4
90212	- over 10 cm. ....	101.05	24.51	112.28	5 5
<b>Congenital dermoid cyst</b>					
90214	- adult .....	113.60	24.51	126.22	4 4
90216	- infant or child.....	183.55	24.51	203.94	4 4
90218	- midline, e.g. nasal .....	249.12	24.51	276.79	4 4
90220	Giant cell tumour.....	113.60	24.51	126.22	4 4
<b>Excision of Pressure sore or decubitus ulcer (IOP)</b>					
90224	- minor, less than 1 cm. average diameter .....	30.54		33.93	4 4
90226	- intermediate, 1-5 cm. average diameter.....	65.48		72.75	4 4
90228	- major or complex.....	IC		IC	5 5
<b>Pilonidal cyst</b>					
90234	- simple excision or marsupialization.....	160.98	24.51	178.87	4 4
90236	- excision and skin shift .....		24.51	242.96	4 4
<b>Inguinal, perineal or axillary skin and sweat glands for hyperhidrosis and/or hidradenitis</b>					
90240	- unilateral.....		24.51	222.90	5 5
90242	- with skin graft(s) or rotation flap(s) .....		24.51	338.60	6 6

**SURGICAL PROCEDURES**

**OPERATIONS ON THE INTEGUMENTARY SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b><u>Excision of Malignant and Premalignant Lesions</u></b>						
<b>Single or multiple sites, uni or bilateral (Includes biopsy of each lesion)</b>						
<b>Simple excision</b>						
Face or Neck						
90246	- single lesion .....	66.44	24.51	73.82	4	4
90248	- 2 lesions .....	109.21	24.51	121.34	4	4
90250	- 3 or more lesions .....	218.52	24.51	242.80	4	4
Other areas						
90252	- single lesion .....	53.13	24.51	59.03	4	4
90253	- 2 lesions .....	87.39	24.51	97.10	4	4
90254	- 3 or more lesions .....	174.78	24.51	194.20	4	4
90256	- in hospital excision tumour for tumour free margins with frozen section (payable in addition to excision or repair fees) .....			56.65		
<b>Curettage, electrodesiccation or cryosurgery of malignant and premalignant lesions</b>						
Face or Neck						
90258	- single lesion .....	56.35	24.51	62.61	4	4
90260	- 2 lesions .....	91.08	24.51	101.20	4	4
90262	- 3 or more lesions .....	182.07	24.51	202.30	4	4
Other areas						
90264	- single lesion .....	44.37	24.51	49.30	4	4
90266	- 2 lesions .....	73.08	24.51	81.20	4	4
90268	- 3 or more lesions .....	168.15	24.51	186.83	4	4
90270	Chemosurgery (Mohs technique) .....			IC	IC	IC
<b><u>Repair</u></b>						
90300	Severe contracture release by excision of scar, e.g., joint			100.00	4	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 .....	VF		VF		
90304	- major .....	11.16		12.40		
90306	- requiring general anaesthetic .....		32.68	50.40	4	4
90308	- extensive .....	IC	32.68	IC	5	5

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE INTEGUMENTARY SYSTEM**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>Repair (Cont'd)</b>						
<b>Suture of Laceration (IOP)</b>						
90310	- up to 5 cm. ....	13.57		15.07	4	4
90312	- up to 5 cm. if on face and/or requires tying of bleeders and/or closure in layers.....	32.53		36.14	4	4
90314	- 5.1 to 10 cm. ....	32.53		36.14	4	4
90316	- 5.1 to 10 cm. if on face and/or requires tying of bleeders and/or closure in layers.....	65.16		72.40	4	4
90318	- 10.1 to 15 cm. ....	46.09		51.21	4	4
90320	- 10.1 to 15 cm. if on face and/or requires tying of bleeders and/or closure in layers.....	92.59		102.88	4	4
90322	- more than 15 cm. ....	IC		IC	4	4
90324	- if inhalation general anaesthesia (other than 50% N <sub>2</sub> O/O <sub>2</sub> mixture) is used..... add	50.23		55.83		
90326	- when rendered in private office or home ..... add	9.46		10.51		
<i>NOTE: The above benefits include the use of sutures, local anaesthetic and tetanus toxoid.</i>						
<b>Muscle Repair</b>						
90330	- simple muscle repair to include repair of involved skin		24.51	79.30	4	4
90332	- complex.....	IC	32.68	IC	6	6
<b>Scar Revision - any method of closure</b>						
Up to 2.5 cm.						
90336	- face or neck.....		24.51	106.30	4	4
90338	- other areas.....		24.51	71.10	4	4
2.6 to 5 cm.						
90340	- face or neck.....		24.51	179.15	4	4
90342	- other areas.....		24.51	119.60	4	4
5.1 to 10 cm.						
90344	- face or neck.....		24.51	255.40	5	5
90346	- other areas.....		24.51	170.60	5	5
90348	Greater than 10 cm. ....		32.68	IC	6	6
<b>Tissue Expanders</b>						
90352	Insertion by separate incision .....		24.51	<b>195.19</b>	5	5
90358	Percutaneous inflation of tissue expander, per visit (IOP) .			<b>22.88</b>		
90360	Inflation of each additional expander to a maximum of 3 .....			<b>11.44</b>		
	..... add					
90362	Replacement of tissue expander by permanent prosthesis (IOP).....			<b>194.28</b>	4	4

## SURGICAL PROCEDURES

## OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>Repair (Cont'd)</b>						
<b>Skin Flaps</b>						
<b>Advancement flaps (to include undermining of more than 2.5 cm. per side) is intended to include excision of a lesion if this is technique of closure</b>						
Defect 2.1 to 5 cm.						
90370	- face or neck .....		24.51	82.60	4	4
90372	- other areas .....		24.51	61.90	4	4
Defect 5.1 to 10 cm.						
90374	- face or neck .....		24.51	227.10	5	5
90376	- other areas .....		24.51	148.60	5	5
90378	Defect larger than 10 cm. ....		32.68	IC	6	6
<b>Rotations, Transpositions, "Z" plasties (includes undermining)</b>						
Defect less than 2 cm.						
90382	- face or neck .....		24.51	183.45	4	4
90384	- other areas .....		24.51	122.60	4	4
Defect 2.1 to 5 cm.						
90386	- face or neck .....		24.51	308.10	4	4
90388	- other areas .....		24.51	205.30	4	4
Defect 5.1 to 10 cm.						
90390	- face or neck .....		32.68	439.90	4	4
90392	- other areas .....		32.68	292.70	4	4
90394	Defect larger than 10 cm. ....		32.68	IC	5	5
<b>Pedicle Flaps</b>						
90398	Small, e.g., cross finger .....		32.68	<b>132.32</b>	4	4
90400	- each subsequent stage .....		32.68	<b>98.11</b>	4	4
90402	Intermediate, e.g. cervical finger .....		32.68	<b>291.41</b>	5	5
90404	- each subsequent stage .....		32.68	<b>221.58</b>	5	5
90406	Large, e.g., cross leg, deltopectoral, forehead .....		32.68	<b>413.05</b>	6	6
90408	- each subsequent stage .....		32.68	<b>309.01</b>	6	6
90410	Preparation of a contracted recipient site, add to 90402 or 90406 .....		24.51	<b>133.73</b>	4	4
90412	Delay of tube or pedicle .....		24.51	<b>62.65</b>	4	4
90414	Delay, intermediate flap .....		24.51	<b>131.35</b>	4	4
90416	Delay, major flap .....		32.68	<b>289.58</b>	5	5
<b>Myocutaneous flaps (to include closure by any means)</b>						
90420	Sternomastoid, tensor fascia lata, gluteus maximus, gracilis, satorius, rectus femoris, gastrocnemius, trapezius .....		24.51	613.30	5	5
90422	Pectoralis major, latissimus dorsi, unilateral rectus abdominus .....		32.68	<b>734.95</b>	6	6
90424	Lower transverse rectus abdominus flap .....		49.02	<b>984.55</b>	8	8
90426	- repair of abdominal defect - same surgeon .....			<b>321.00</b>		
90428	- different surgeon .....			<b>377.65</b>		
90430	Myocutaneous - osseous flaps .....		49.02	720.00	8	8
90432	Other .....		IC	IC	8	8

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE INTEGUMENTARY SYSTEM**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>Repair (Cont'd)</b>					
<b>Skin Grafts (includes taking the skin for grafting)</b>					
<b>Split Thickness Grafts</b>					
90440			<b>92.30</b>	4	4
90442				4	4
90444		24.51	<b>140.25</b>	4	4
90446		32.68	<b>259.10</b>	4	4
90448		32.68	527.27	5	5
			<b>567.95</b>	6	6
<b>Full Thickness Grafts</b>					
90450			93.41	4	4
90452		24.51	131.60	4	4
90454		40.85	<b>280.15</b>	6	6
90456		32.68	258.25	6	6
90460					
90462		IC	IC	IC	IC
		IC	IC	IC	IC
<b>Stasis Ulcer</b>					
90464		24.51	180.00	5	5
90466		40.85	333.54	5	5
<b>Neurovascular Island Transfer</b>					
90470		24.51	129.00	4	4
90472		32.68	238.30	5	5
90474		32.68	396.00	6	6
<b>Free Island Flaps</b>					
Skin and subcutaneous tissue					
90490		81.70	765.50	10	10
90492			810.00		
90494			810.00		
Innervated skin and subcutaneous tissue flap					
90496		81.70	900.10	10	10
90498			900.10		
90500			841.50		
Skin and muscle flap					
90502		81.70	765.50	10	10
90504			810.00		
90506			765.50		
Muscle with tendon and nerve					
90508		81.70	1035.55	10	10
90510			1035.55		
90512			1035.55		



**SURGICAL PROCEDURES  
OPERATIONS ON THE INTEGUMENTARY SYSTEM**

<b>Code</b>		<b>G.P.</b>	<b>Assist</b>	<b>Spec.</b>	<b>Spec. Anaes.</b>	<b>G.P. Anaes.</b>
<b>Repair (Cont'd)</b>						
<b>Skin Grafts (includes taking the skin for grafting) (Cont'd)</b>						
<b>Free Island Flaps (Cont'd)</b>						
Bone flap						
90514	- elevation .....		81.70	765.50	10	10
90516	- preparation of site .....			810.00		
90518	- transplantation .....			900.10		
Skin and bone flap						
90520	- elevation .....		81.70	918.30	10	10
90522	- preparation of site .....			918.30		
90524	- transplantation .....			918.30		
Free toe or finger						
90526	- elevation .....		81.70	918.30	10	10
90528	- preparation of site .....			918.30		
90530	- transplantation .....			1080.10		
90532	Revision of free island flaps .....		81.70	IC	10	10
90534	Flaps other than above.....		IC	IC	IC	IC
90540	Digital reimplantation.....		65.36	1439.40	10	10
<b>Destruction</b>						
Finger or toenail (IOP)						
Simple, partial or complete						
90550	- 1.....	19.17		21.30	4	4
90552	- multiple .....	28.71		31.90	4	4
Radical, including destruction of nail bed						
90554	- 1.....	47.79		53.10		
90556	- multiple .....	66.69		74.10	4	4
					4	4
Chemical and/or cryotherapy treatment of minor skin lesions (IOP)						
90560	- 1 or more lesions, per treatment .....	8.91		9.90		
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	4
90578	- both cheeks .....			189.00	4	4
90580	- whole face .....			288.00	4	4
90582	- single area, e.g., trauma scar .....			51.65	4	4
90584	Rhinophyma, removal by shaving .....			231.40	4	4
<b>Webbed Fingers</b>						
90590	- 1 web space .....		32.68	<b>267.34</b>	5	5
<b>Webbed Toes</b>						
90596	- 1 web space .....		32.68	<b>122.83</b>	4	4

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE INTEGUMENTARY SYSTEM**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>Repair (Cont'd)</b>					
<b>Burns</b>					
Resuscitation - major burn					
90600					<b>102.64</b>
90602					<b>51.38</b>
For burn care requiring Anaesthesiologist's and/or assistant's services, the following fees apply:					
90610		32.68		5	5
90612		49.02		10	10
90614		65.36		15	15
90620					<b>28.60</b>
Debridement and excision, per % of total body treated (other than hand, head or neck) .....					
Debridement and excision					
90622					<b>28.60</b>
90624					<b>47.60</b>
90626					<b>28.60</b>
90640					<b>47.60</b>
Grafting of burn, per % of total body treated (other than hand, head or neck).....					
Graft of burn					
90644					<b>57.10</b>
90646					<b>114.30</b>
90648					<b>190.55</b>
90650					<b>190.55</b>
90652					<b>190.55</b>
90654					<b>190.55</b>
90656					<b>95.30</b>
90658					<b>238.20</b>
90660					IC
90662					<b>95.30</b>
90664					<b>209.49</b>
90666					IC
<b>Subdermal Birth Control Devices (IOP)</b>					
90668					40.00
90669					60.00

**SURGICAL PROCEDURES**

**OPERATIONS ON THE INTEGUMENTARY SYSTEM**

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

<b>Code</b>	<b>G.P.</b>	<b>Assist</b>	<b>Spec.</b>	<b>Spec. Anaes.</b>	<b>G.P. Anaes.</b>
90670 Very minor plastic surgery procedures .....			<b>97.68</b>	4	4
90672 Minor .....		24.51	<b>148.40</b>	4	4
90674 Intermediate .....		32.68	<b>274.25</b>	4	4
90676 Major .....		32.68	<b>410.57</b>	5	5
90678 Extensive major.....		32.68	<b>602.04</b>	6	6

**SURGICAL PROCEDURES**  
**OPERATIONS ON THE BREAST**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>Incision</b>						
90680	Needle biopsy - 1 or more (IOP) .....	21.88		24.31		
90682	Aspiration of cyst - 1 or more (IOP) .....	20.07		22.30		
	Drainage of intramammary abscess single or multiloculated (IOP)					
90684	- local anaesthetic.....	20.07		22.30		
90686	- general anaesthetic.....	55.08		61.20	4	4
<b>Excision</b>						
90700	Tumour or tissue for biopsy (single or multiple - same breast) .....	112.15	24.51	124.62	4	4
90701	- with wire/needle localization..... add			76.38		
90702	Partial mastectomy or wedge resection .....		24.51	221.10	4	4
90704	- with radical axillary node dissection .....			383.12	2	2
	Mastectomy - male (benign)					
90706	- unilateral - simple .....		24.51	241.20	4	4
90708	- subcutaneous with nipple preservation .....		32.68	265.31	5	5
	Mastectomy - female (with or without biopsy)					
90710	- simple.....	238.78	24.51	265.31	5	5
90712	- subcutaneous with nipple preservation .....		24.51	265.31	5	5
90714	Mastectomy, radical or modified radical (with or without biopsy).....		24.51	562.80	6	6
<b>Repair</b>						
	Post-mastectomy breast reconstruction					
90720	- breast mound creation by prosthesis and/or soft tissue .....		32.68	<b>333.47</b>	5	5
90724	- breast skin reconstruction by local flaps or grafts.....		32.68	<b>438.58</b>	5	5
90726	- with breast mound creation by prosthesis and or soft tissue .....			<b>101.78</b>		
90728	- revision of breast mound .....		24.51	<b>253.40</b>	4	4
	Nipple-areolar					
90730	- preservation and tissue banking.....		24.51	<b>116.57</b>	4	4
90732	- reimplantation of banked nipple-areola .....		24.51	<b>135.99</b>	4	4
90734	- nipple reconstruction by grafts .....		24.51	<b>228.49</b>	4	4
90740	Reduction mammoplasty (female, to include nipple transplantation or grafting) - unilateral .....		40.85	<b>490.10</b>	7	7
90744	Augmentation mammoplasty - unilateral.....		32.68	<b>198.92</b>	4	4
90748	Removal of breast prosthesis and/or fibrous capsule (IOP)		24.51	<b>85.76</b>	4	4
	Breast capsulotomy, closed (IOP)					
90750	- no anaesthetic.....			<b>12.25</b>		
90752	- general anaesthetic.....		24.51	<b>78.68</b>	4	4
90754	Open capsulectomy with or without replacement of breast prosthesis (IOP) .....		24.51	<b>194.28</b>	4	4
90756	Myocutaneous flaps, pectoralis major, latissimus dorsi, unilateral rectus .....		32.68	<b>729.07</b>	6	6

**SURGICAL PROCEDURES**

**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. and on Sundays or Statutory Holidays or are performed by Specialist Surgeons and commenced between 7:00 a.m. and 6:00 p.m. on Saturdays.

<b>Prem Code</b>		<b>G.P.</b>	<b>Assist</b>	<b>Spec.</b>	<b>Spec. Anaes.</b>	<b>G.P. Anaes</b>
01	Procedures that qualify and commence between 6:00 p.m. and midnight or on Sundays or Statutory Holidays or are rendered by Specialist Surgeons between 7:00 a.m. and 6:00 p.m. on Saturday ..... add	30%	30%	30%		
02	Procedures that qualify and commence between 6:00 p.m. and midnight or on Sundays or Statutory Holidays or are rendered by Specialist Surgeons between 7:00 a.m. and 6:00 p.m. on Saturday(Anaesthesiologists only) ..... add				46%	46%
03	Procedures that qualify and commence any night between midnight and 7:00 a.m..... add	50%	50%	50%	50%	50%

## SURGICAL PROCEDURES

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>SPECIAL PROCEDURES</b>						
90008	Examination under general anaesthesia (when not elsewhere specified and when sole procedure) (IOP)..			28.34	4	4
90010	Insertion of radium.....				4	4
90012	General anaesthetic for CAT Scan/MRI .....				5	5
90014	Anaesthetic wake-up test .....				6	6
90016	Fibreoptic intubation..... add				10	10
90018	One-lung anaesthesia .....				6	6
90020	Anaesthesiologist or assistant standby at the request of the attending physician (IC).....		24.51		3	3
90022	Monitoring under IV sedation .....				4	4
90024	Anaesthesiology additional fee for children under 1 year of age .....				3	3
90026	Anaesthesiology additional fee for adults 70 or older..add				1	1
90028	For patients of any age with an incapacitating systemic disease that is a constant threat to life or to a moribund patient who is not expected to survive for 24 hours, with or without the operation.....add				1	1
90030	For patients undergoing anaesthesia in the prone or sitting position .....				1	1
90032	For patients undergoing anaesthesia who weigh less than 5 kg .....				3	3
90034	Controlled hypotension.....add				10	10
90036	Malignant hyperthermia set up and management .....				5	5
90038	Anaesthesiology management for the emergency relief of acute upper airway obstruction .....				10	10
90040	Anaesthetic begun and operation cancelled prior to commencement of surgery.....		24.51		4	4

**ANAESTHESIA FOR SURGICAL DENTAL PROCEDURS**

**Code** **Spec. Anaes** **G.P. Anaes**

*For rules applicable to billing for Anaesthesiologists' services including premiums, please refer to the Anaesthesiology Services Section of the Preamble*

**EXTRACTIONS**

84040	Removal of erupted tooth, uncomplicated procedure.....	4	4
84044	Surgical removal of erupted tooth, requires elevation of mucoperiosteal flap, and removal of bone and/or sectioning of tooth.....	4	4
84046	Removal of residual roots - covered by soft tissue.....	4	4
84050	- covered by bone.....	4	4

**EXTRACTION OF IMPACTED TEETH**

84060	Impaction, requires incision of overlying soft tissue and removal of tooth.....	4	4
84062	Impaction, requires incision of overlying soft tissue, elevation of flap, and either removal of bone or sectioning and removal of tooth.....	4	4
84064	Impaction, requires incision of overlying soft tissue, elevation of flap and removal of completely bone covered tooth.....	4	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	4

**SURGICAL EXPOSURE OF TEETH**

Surgical exposure			
84070	- uncomplicated, soft tissue coverage.....	4	4
84072	- complex, hard tissue coverage.....	4	4
84074	- unerupted tooth with orthodontic attachment.....	4	4

**SURGICAL MOVEMENT OF TEETH**

84080	Repositioning, surgical.....	4	4
84082	Transplantation - erupted tooth.....	4	4
84084	- unerupted tooth.....	4	4

**REMODELLING AND RECONTOURING ORAL TISSUES**

84100	Alveoloplasty - in conjunction with extractions.....	4	4
84102	- not in conjunction with extractions.....	4	4

**Remodelling of Bone**

84104	Mylohyoid ridge, remodelling.....	4	4
84106	Genial tubercles, remodelling.....	4	4

**Excision of Bone**

84108	Nasal bone.....	4	4
84110	Torus palatinus.....	4	4
84112	Torus mandibularis.....	4	4

84114	<b>Removal of Bone, Exostosis, Multiple</b> .....	4	4
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84116	<b>Reduction of Bone, Tuberosity</b> .....	4	4
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## ANAESTHESIA FOR SURGICAL DENTAL PROCEDURS

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



## ANAESTHESIA FOR SURGICAL DENTAL PROCEDURS

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

**ANAESTHESIA FOR SURGICAL DENTAL PROCEDURS**

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

## ANAESTHESIA FOR SURGICAL DENTAL PROCEDURS

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

## ANAESTHESIA FOR SURGICAL DENTAL PROCEDURS

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

## ANAESTHESIA FOR SURGICAL DENTAL PROCEDURS

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

## ANAESTHESIA FOR SURGICAL DENTAL PROCEDURS

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

**ANAESTHESIA FOR SURGICAL DENTAL PROCEDURS**

Code		Spec. Anaes	G.P. Anaes
<b>SPECIAL PROCEDURES</b>			
84920	Anaesthetic standby at the request of the attending physician .....	3	3
84922	Monitoring under IV sedation .....	4	4
84926	Anaesthetic additional fee for adults 70 or older ..... add	1	1
84930	For patients undergoing anaesthesia in the prone or sitting position .....	1	1
84934	Controlled hypotension ..... add	10	10

**OBSTETRICS**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>OBSTETRICAL CARE</b>						
80002	Multiple births - each child extra.....		<b>56.57</b>		<b>62.86</b>	
80004	Delivery .....		<b>448.49</b>		<b>448.49</b>	
80006	Vaginal birth following a Caesarean Section.....add		<b>24.33</b>		<b>27.03</b>	
80007	Premium on deliveries occurring between 6:00 p.m. and midnight .....		75.00		No Fee	
80008	Premium on deliveries occurring between midnight and 7:00 a.m. ....		125.00		125.00	
	This premium is <u>not</u> chargeable in addition to the obstetrical fee(s) if labour is induced by medical and/or surgical means by the same physician unless the reason for the induction is foetal distress, diabetes, pre-mature rupture of membrane, severe pre-eclampsia - hypertension or abruption.					
	A forewater ARM or oxytocin augmentation of labour carried out on a patient in desultory labour <u>does not</u> constitute induction.					
80010	Post-natal care in hospital.....		32.00		34.80	
80012	Post-natal care in office.....		13.50		17.00	
80014	Attendance at labour (may be claimed <u>in addition</u> to subsequent assist at Caesarean Section or other operative delivery .....		423.10		No Fee	
80016	Attendance at delivery.....				44.91	
<b>High risk pregnancies</b>						
80018	Fetal Doppler arterial flow frequency analysis (IOP) .....				15.00	
80020	Fetoscopy (may include fetal blood sample, cell harvest or amniocentesis) (IOP) .....				146.10	
80024	Double set up examination to rule out placenta previa - patient subsequently allowed to labour (same physician).....				50.00	
80026	Double set up - trial of forceps - failed leading to Caesarean Section (same physician).....				50.00	
80028	Chorionic villus sampling (IOP) .....				81.60	
80030	Application of scalp electrode in high risk pregnancy.....		15.16		16.84	
80032	Insertion of intrauterine catheter.....				16.84	
80034	Foetal scalp blood sampling.....		27.00		30.00	



**OBSTETRICS**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>ANAESTHESIOLOGY</b>						
80040	Anaesthesia for delivery .....				5	5
80042	Continuous conduction anaesthesia for labour, introduction of catheter.....				5	5
80044	Maintenance of continuous conduction anaesthesia (1 unit for each subsequent injection or ¼ hour of maintenance, <u>maximum</u> of 12 units) per unit.....				1	1
	<i>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. (<u>Claim IC</u> when total epidural/anaesthetic time units in the above combination exceed 12).</i>					
80046	Anaesthesiologist called to attend obstetrical delivery without participation (IC) .....				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**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>OPERATIVE DELIVERY, excluding low or outlet forceps delivery</b>						
81002	- Caesarean Section with or without sterilization, procedure and post-operative care only .....	<b>449.50</b>	49.02	<b>499.45</b>	6	6
81004	- Caesarean Section, plus hysterectomy .....	<b>527.33</b>	49.02	<b>585.93</b>	8	8
81006	- Operative delivery - other than Caesarean Section...	<b>435.93</b>	49.02	<b>484.37</b>	5	5
81008	Premium on Caesarean Sections and operative deliveries occurring between midnight and 7:00 a.m. ....	125.00		125.00		

*This premium is not chargeable in addition to the obstetrical fee(s) if labour is induced by medical and/or surgical means by the same physician unless the reason for the induction is foetal distress, diabetes, premature rupture of membrane, severe pre-eclampsia - hypertension or abruption.*

*A forewater ARM or oxytocin augmentation of labour carried out on a patient in desultory labour does not constitute induction.*

## OBSTETRICS

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>SURGICAL OBSTETRICS</b>						
<b>Induction</b>						
<b>Notes:</b>						
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	3
81012	Medical induction of labour (oxytocin infusion).....	42.44		47.15		
<b>Abortion</b>						
	- complete - under 20 weeks	VF		VF		
81014	- D&C for incomplete abortion (IOP).....	58.50		65.00	4	4
81016	- therapeutic.....	112.78		131.91	4	4
81018	Amniocentesis (IOP) .....			51.90		
81020	Hysterotomy - abdominal or vaginal with or without sterilization .....		49.02	194.10	6	6
81022	Missed abortion, with or without intra-uterine hypertonic solution.....			131.91	4	4
81024	Repair of third degree laceration .....			69.61	4	4
81026	Repair of vaginal laceration and/or large haematoma.....	42.44		47.15	4	4
81028	Retained placenta removal.....	42.44		47.15	4	4
<i>Fee codes 81024, 81026 and 81028 are <u>not</u> payable to the same physician in addition to the delivery fee.</i>						
81030	Ectopic pregnancy.....	181.98	49.02	202.20	6	6
81032	Suture of incompetent cervix during pregnancy .....	111.15	24.51	123.50	4	4
81034	Emergency removal of sutures (except at delivery).....				4	4
81036	Sterilization - post partum (same physician), in addition to delivery and post partum fee .....		49.02	114.50	6	6
81038	Uterine inversion, manual replacements .....			95.43	4	4

**NUCLEAR MEDICINE**

Code		Rate
<p><i>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".</i></p>		
<b>Cardiovascular System</b>		
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.....	16.31
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 .....	53.91
75008	- delayed.....	28.69
75009	- with computer data manipulation..... add	23.09
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 .....	89.80
75014	- repeat same day (max. of 3 repeats) .....	43.98
75015	- with computer data manipulation..... add	26.02
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).....	25.33
<b>Endocrine System</b>		
75020	Adrenal scintigraphy with iodocholesterol.....	66.15
75021	- with iodocholesterol and dexamethasone suppression .....	66.15
75022	- with MIBG.....	58.62
Thyroid uptake		
75023	- initial.....	21.26
75024	- repeat.....	10.63
Thyroid scintigraphy		
75025	- with TC99m or I-131 .....	38.60
75026	- with I-123.....	43.60
Parathyroid scintigraphy		
75027	- dual isotope technique with T1201 and TC99m iodine.....	73.28
75028	- with computer data manipulation..... add	21.99
75029	Metastatic survey with I-131.....	61.62
<b>Gastrointestinal System</b>		
75034	C15 breath test for <i>Helicobacter pylori</i> .....	17.13
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

Code		Rate
<b>Gastrointestinal System (Cont'd)</b>		
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.....	51.12
75045	Gastroesophageal reflux .....	49.60
75046	Gastroesophageal aspiration.....	33.10
	Abdominal scintigraphy for gastrointestinal bleed	
75047	- TC99m sulphur colloid or TC04 .....	40.06
75048	- labelled RBCs.....	55.64
75049	- LeVeen shunt potency .....	43.98
75050	Biliary scintigraphy.....	69.73
75051	Liver/spleen scintigraphy .....	40.06
75053	Salivary gland scintigraphy.....	32.60
75054	With computer data manipulation .....	14.66
		add
<b>Genitourinary System</b>		
75060	Dynamic renal imaging .....	73.28
75061	Computer renal function (includes first transit) .....	73.28
75062	- repeat after pharmacological intervention.....	21.02
75063	Static renal scintigraphy .....	13.31
75064	ERPF by blood sample method .....	10.63
75065	GFR by blood sample method.....	21.60
75066	Cystography for vesicoureteric reflux .....	32.60
75067	Testicular and scrotal scintigraphy (includes first transit) .....	55.93
75068	With computer data manipulation .....	21.99
		add
<b>Hematopoietic System</b>		
75069	Plasma volume.....	8.99
75070	Red cell volume.....	8.99
75071	Ferrokinesis - 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	
75075	Single site.....	47.88
75076	In-111 leukocyte scintigraphy - whole body.....	69.21
75077	- single site .....	54.11
75078	Indium-CL scintigraphy.....	47.88
75079	With computer data manipulation .....	13.43
		add
<b>Musculoskeletal System</b>		
75080	Bone scintigraphy - general survey .....	61.38
75081	- single site .....	47.00
75082	Gallium scintigraphy - general survey .....	65.19
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.....	55.00
75088	With computer data manipulation .....	15.11
		add

**NUCLEAR MEDICINE**

Code		Rate
<b>Nervous System</b>		
CSF circulation		
75090	- with TC99 m or I-131 HSA .....	54.42
75091	- with Indium-III.....	57.28
75092	- via shunt puncture.....	61.62
75093	Brain scintigraphy .....	38.60
75094	- cerebral blood flow study..... add	19.88
75095	- with computer data manipulation..... add	14.66
75096	HMPAO regional brain perfusion with SPECT .....	67.92
<b>Respiratory System</b>		
75100	Perfusion lung scintigraphy .....	46.66
75101	Ventilation lung scintigraphy .....	46.66
75102	Perfusion and ventilation scintigraphy - same day .....	88.37
75103	With computer data manipulation..... add	10.99
<b>Miscellaneous</b>		
75200	Radionuclide lymphangiogram.....	69.26
75201	Ocular tumor localization.....	77.25
75202	Tear duct scintigraphy.....	55.95
75203	Total body counting.....	62.67
75205	Other scan (approved but not currently listed) .....	55.95
75206	With computer data manipulation..... add	10.99
<b>SPECT</b>		
75210	SPECT - Single Photon Emission Computerized Tomography.....	34.33
75212	SPECT - with transmission attenuation correction.....	45.32
<b>Notes:</b>		
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.		
<b>Special Visit Premiums</b>		
75227	Daytime special visit (Monday to Saturday) .....	31.57
75228	Evening (6 p.m. to midnight) and Sunday and Statutory Holidays .....	105.23
75229	Night (midnight to 8 a.m.).....	157.85
<b>Note:</b> 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.		
<b>Therapy using Radioisotopes</b>		
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 .....	87.80
75251	Hyperthyroidism .....	79.81
75252	Induction of hypothyroidism .....	79.81
75255	Prostate malignancy .....	79.81
75256	Polycythaemia.....	45.57
75257	Metastatic disease of bone .....	72.63
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

## RADIOLOGY

Code		Rate
<b>GENERAL RADIOLOGY</b>		
<b>Head and Neck</b>		
70100	Skull - routine (includes Towne's views) .....	13.53
70101	Sella turcica .....	6.77
70110	Facial bones.....	10.84
70111	Nose.....	6.77
70112	Mandible .....	8.13
70113	Temperomandibular joints.....	10.84
70120	Sinuses .....	9.50
70121	Mastoids - acute .....	10.84
70122	- chronic .....	10.84
70130	Teeth - up to ¼ set.....	2.73
70131	- up to ½ set .....	6.09
70132	- full set .....	12.18
70133	- bitewing.....	4.05
70140	Eye, for foreign body.....	12.18
70141	- for localization (stereo-optics), additional.....	24.11
70142	Optic foramina.....	9.50
70150	Salivary gland region.....	8.13
70160	Neck for soft tissues.....	8.13
70170	Internal auditory canal.....	10.84
70190	Special additional view of any head and neck item.....	2.89
<b>Spine and Pelvis</b>		
70200	Cervical spine .....	13.53
70210	Thoracic spine.....	13.53
70220	Lumbar or lumbosacral spine.....	13.53
70225	Sacrum and/or coccyx.....	6.77
70230	Pelvis - single view.....	8.13
70235	Pelvis and hips.....	10.84
70240	Sacroiliac joints .....	8.13
70245	Spine - scoliosis series.....	21.64
70250	Ribs - unilateral .....	8.13
70251	- for bilateral, extra .....	5.42
70260	Sternum .....	8.13
70270	Special additional view of any spine and pelvis item.....	2.89
<b>Extremities</b>		
70300	Clavicle .....	8.13
70301	Sternoclavicular joint.....	8.13
70303	Acromioclavicular joints - bilateral (with or without weighted distraction) .....	8.13
70310	Shoulder.....	8.13
70320	Scapula.....	8.13
70330	Humerus .....	8.13
70331	Elbow .....	8.13
70332	Ulna and radius.....	8.13
70333	Wrist .....	8.13
70334	Wrist and Hand .....	8.13
70335	Hand .....	8.13
70336	Finger .....	5.41
70337	Thumb, including metacarpals .....	6.77
70338	Scaphoid.....	8.13
70350	Hip .....	8.13
70351	Hip pinning, interpretation only.....	8.13

RADIOLOGY

Code		Rate
<b>GENERAL RADIOLOGY (Cont'd)</b>		
<b>Extremities (Cont'd)</b>		
70352	Femur .....	8.13
70353	Orthoroentgenogram .....	10.84
70360	Knee (including patella) .....	10.65
70364	Tibia and fibula .....	8.13
70366	Ankle .....	8.13
70368	Calcaneous .....	8.13
70370	Foot .....	8.13
70380	Toe .....	5.41
70390	Special additional view of any item in the section headed "extremities" .....	2.89
70395	Post reduction check .....	8.13
<b>Skeletal Surveys</b>		
Skeletal survey for bone age		
70430	- single film.....	6.77
70431	- 2 or more films or views.....	10.84
<b>Other Surveys</b>		
70440	- basic for rheumatoid survey.....	3.12
70450	- basic for metabolic survey .....	3.12
70460	- basic for metastatic survey .....	3.12
70465	- plus per film or view for either of the above .....	3.12
<b>Chest</b>		
70501	Single film.....	5.82
70502	2 views .....	8.71
70503	3 or more views .....	11.59
70520	Mammography - unilateral.....	17.60
70522	- bilateral.....	27.99
70525	Screening mammography program .....	16.79
<b>NOTE:</b> Fee code 70525 should be claimed for screening mammograms performed at either the Health Care Corporation in St. John's or at the James Paton Memorial Hospital as part of the screening program established by the Department of Health and Community Services. All other mammograms performed and reported at these and other sites should continue to be billed as either fee code 70520 or 70522.		
<b>Abdomen</b>		
70600	Survey film ( <u>not</u> to be billed in addition to 70601).....	8.13
70601	Additional film studies (acute abdomen).....	9.50
70610	Oesophagus.....	21.01
70620	Stomach and duodenum .....	28.75
70621	Stomach and duodenum with small intestinal series .....	41.61
70625	Small bowel only .....	23.21
70626	Upper GI - double contrast .....	39.57
70630	Colon - barium enema.....	27.06
70631	- with air study .....	42.53
70634	Defecography .....	25.45
70640	Cholecystogram .....	10.84
70645	T-Tube cholangiogram .....	21.64
70650	Operative cholangiogram, interpretation only.....	10.84
70651	Intravenous cholangio - tomography .....	16.26
70652	Intravenous cholangiogram .....	16.26



## RADIOLOGY

Code		Rate
<b>GENERAL RADIOLOGY (Cont'd)</b>		
<b>GU Tract</b>		
70700	Survey film .....	8.13
70705	Retrograde pyelogram .....	10.84
70710	Intravenous pyelogram.....	23.11
70714	- with nephrotomogram.....	69.29
70721	Diuretic washout or infusion IVP .....	69.29
70724	- with nephrotomogram.....	32.47
70730	Urethrocystogram .....	8.13
70735	Stress urethrocystogram.....	20.61
70738	Voiding urethrocystogram .....	20.61
70741	Vasography.....	8.13
70745	Nephrostogram .....	13.53
<b>Obstetrics and Gynaecology</b>		
70800	Survey film .....	6.69
70810	Pelviometry .....	21.64
70814	Placentogram.....	8.91
70824	Hysterosalpingogram .....	13.53
70830	Intra-uterine foetal transfusion - radiological control .....	28.15

## RADIOLOGY

Code		Rate
<b>SPECIAL PROCEDURES</b>		
<b>Arteriography - General</b>		
	Flush aortograph - includes aortic root, thoracic, lumbar and retrograde femoral	
71100	- procedure .....	109.07
71101	- interpretation.....	42.36
	Translumbar aortography	
71105	- procedure .....	109.07
71106	- interpretation.....	42.36
	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 .....	22.82
71190	Percutaneous transhepatic catheter portal venography .....	240.33
<b>Venous Studies</b>		
	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.....	42.36
	Single peripheral venogram (lower limb, orbital, etc.)	
71216	- procedure .....	32.73
71217	- interpretation.....	42.36
	Bilateral peripheral and pelvic	
71220	- procedure .....	54.53
71221	- interpretation.....	70.57
	Splenoportogram	
71225	- procedure .....	54.53
71226	- interpretation.....	28.23
	Lymphangiogram - single	
71230	- procedure .....	54.53
71231	- interpretation.....	28.23

RADIOLOGY

Code		Rate
<b>SPECIAL PROCEDURES (Cont'd)</b>		
<b>Venous Studies (Cont'd)</b>		
Lymphangiogram - bilateral		
71232	- procedure .....	109.07
71233	- interpretation .....	56.49
<b>Cardiac Angiography</b>		
All cardiac angiography except bilateral coronary studies		
71301	- interpretation .....	53.78
Bilateral coronary angiography		
71306	- interpretation .....	110.34
<i>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.</i>		
<b>Neuro Angiography</b>		
71390	Percutaneous embolization of spinal or cerebral AV malformations .....	370.37
71394	Carotid or vertebral artery occlusion by detachable balloon - percutaneous.....	259.19
Percutaneous carotid angiogram - single (brachial)		
71400	- procedure .....	<b>168.56</b>
71401	- interpretation .....	<b>56.29</b>
Percutaneous carotid angiogram - bilateral		
71402	- procedure .....	<b>303.40</b>
71403	- interpretation .....	<b>93.78</b>
For repeat angiograms (oblique vies, stereo magnification, basil, etc.)		
71404	- procedure - single .....	<b>202.26</b>
71405	- interpretation - single.....	<b>56.29</b>
71406	- procedure - bilateral .....	<b>364.09</b>
71407	- interpretation - bilateral.....	<b>93.78</b>
Myelogram (complete) prone		
71410	- procedure .....	<b>89.90</b>
71411	- interpretation .....	<b>37.51</b>
Myelogram - supine (second puncture)		
71415	- procedure .....	add 33.81
Posterior fossa myelogram		
71421	- procedure .....	add 33.81
Discography		
71425	- procedure .....	50.72
71426	- interpretation .....	28.23
Discography (each additional level)		
71427	- procedure .....	add 25.37
Risagram		
71451	- interpretation .....	84.75
<b>Gastro-Intestinal</b>		
Sialogram		
71500	- procedure .....	21.81
71501	- interpretation .....	14.11
Insertion of nasogastric tube		
71504	- procedure .....	7.61
Ba. swallow H-type fistula		
71508	- procedure .....	33.81
71509	- interpretation .....	IC
71510	Percutaneous gastrostomy .....	<b>230.24</b>

## RADIOLOGY

Code		Rate
<b>SPECIAL PROCEDURES (Cont'd)</b>		
<b>Gastro-Intestinal (Cont'd)</b>		
	Hypotonic duodenography	
71514	- procedure .....	21.81
71515	- interpretation.....	IC
71518	Biliary duct calculus removal via T-Tube tract .....	69.54
71519	Percutaneous transhepatic biliary drainage including biliary stenting.....	<b>386.24</b>
	Transhepatic cholangiogram	
71520	- procedure .....	<b>72.46</b>
71521	- interpretation.....	<b>37.51</b>
71522	Change of biliary drainage tube.....	<b>144.94</b>
71523	Injection of biliary drainage tube for reassessment .....	<b>37.51</b>
71524	ERCP - total procedure performed by a Radiologist .....	216.37
71525	- interpretation .....	9.65
	Small bowel enema	
71528	- procedure .....	63.82
71529	- interpretation .....	14.11
	Reduction of intussusception	
71534	- procedure .....	33.80
71535	- interpretation.....	IC
71536	Oral or percutaneous placement of jejunostomy tube .....	63.82
	Gastrografin enema	
71538	- procedure .....	33.80
71539	- interpretation.....	IC
	Pneumoperitoneal and retroperitoneal air insufflation	
71541	- procedure .....	76.37
71542	- interpretation.....	42.36
	Sinogram	
71549	- procedure .....	21.81
71550	- interpretation.....	14.11
	Dacrocystogram	
71560	- procedure .....	21.81
71561	- interpretation.....	14.11
71570	Abscess management (intra-abdominal or deep organ) i.e. localization, placement of tube, drainage under fluoroscopy, ultrasound and/or CT.....	124.23
<b>Respiratory System</b>		
	Laryngogram	
71600	- procedure .....	21.81
71601	- interpretation.....	28.39
	Single bronchogram	
71612	- procedure .....	21.81
71613	- interpretation.....	28.39
	Bilateral bronchogram	
71614	- procedure .....	32.73
71615	- interpretation.....	42.36
	Percutaneous lung biopsy	
71618	- procedure .....	76.37
71619	- interpretation.....	IC
	Injection of air into the anterior mediastinum	
71624	- procedure .....	54.53
71625	- interpretation.....	14.11

RADIOLOGY

Code		Rate
<b>SPECIAL PROCEDURES (Cont'd)</b>		
<b>Respiratory System (Cont'd)</b>		
	Injection of contrast into pleural cavity	
71626	- procedure .....	32.73
71627	- interpretation .....	14.11
<b>Genito-Urinary</b>		
	Hysterosalpingogram	
71700	- procedure (fluoroscopy) .....	14.11
71701	- interpretation .....	14.11
	Kidney film	
71710	- procedure (fluoroscopy) .....	14.11
71711	- interpretation .....	14.11
71714	Percutaneous antegrade insertion of ureteric stent.....	<b>102.02</b>
71715	Change of nephrostomy tube.....	<b>144.94</b>
	Cyst puncture (renal)	
71718	- procedure .....	109.07
71719	- interpretation .....	IC
	Injection of dye into cystic cavity	
71724	- procedure .....	32.73
71725	- interpretation .....	14.11
	Loopogram	
71728	- procedure .....	10.93
71729	- interpretation .....	10.93
	Catheterization	
71730	- procedure.....	7.61
71731	- interpretation .....	IC
	Percutaneous nephrostomy	
71740	- performed by a Radiologist .....	<b>175.70</b>
<b>Orthopaedic</b>		
71800	- procedure .....	32.73
71801	- interpretation .....	30.99

RADIOLOGY

Code		Rate
<b>OTHER ITEMS</b>		
<b>Other</b>		
71840	Mammary ductography.....	26.68
71850	Intra-mammary needling for localization under mammographic control (procedure and interpretation - unilateral).....	33.46
<b>Special Visit Premiums</b>		
71927	Daytime special visit (Monday to Saturday).....	33.12
71928	Evening (6:00 p.m. to midnight) and Sunday and Statutory Holidays.....	110.37
71929	Night (midnight to 8:00 a.m.) .....	165.56
<i>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.</i>		
<b>IV Injections</b>		
71941	Adult .....	13.98
71942	Cut-down .....	9.42
71948	Paediatric IV injection.....	9.42
71949	Scalp vein or cut-down .....	18.80
71950	Catheterization .....	9.42
71951	Injection - bursae, joints or tendon sheath.....	14.45
<b>Tomography</b>		
71960	1 plane.....	10.92
71961	2 planes.....	21.77
<b>Fluoroscopy</b>		
71980	Fluoroscopy alone, of any part .....	18.75
71985	Fluoroscopy 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.) .....	24.91

**RADIOLOGY**

Code		Rate
<b>DIAGNOSTIC ULTRASOUND</b>		
Procedure codes indicated as IC <u>must</u> be billed IC indicating why the procedure had to be done by the Radiologist. See item 11.4 of the Preamble.		
<b>General</b>		
72050	Ultrasound control of a procedure, done by another physician, per ¼ hour or part thereof (IC required indicating the name of the procedure, the physician who did the procedure and the amount of time involved).....	24.91
<b>Head and Neck</b>		
Echoencephalography - midline, A-mode		
72100	- interpretation .....	10.95
72101	- procedure (IC) .....	23.22
Complete (midline and ventricular size)		
72104	- interpretation .....	16.47
72105	- procedure (IC) .....	23.22
Echography - ophthalmic		
Quantitative, A-mode		
72110	- interpretation .....	45.10
72111	- procedure (IC) .....	23.22
B-scan immersion		
72112	- interpretation .....	60.12
72113	- procedure (IC) .....	23.22
B-scan contact		
72114	- interpretation.....	30.08
72115	- procedure (IC) .....	23.22
Biometry (axial length - A-mode)		
72116	- interpretation .....	40.09
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 .....	21.90
72131	- procedure (IC) .....	23.22
Neonatal/paediatric cranial scan - complete		
72140	- interpretation .....	36.50
72141	- procedure (IC) .....	23.22
Neonatal/paediatric spinal scan - complete		
72150	- interpretation .....	36.50
72151	- procedure (IC) .....	23.22
<b>Heart/Major Blood Vessel</b>		
Echography, pericardial effusion, M-mode		
72200	- interpretation .....	24.32
72201	- procedure (IC) .....	23.22
Ultrasound pericardiocentesis		
72210	- procedure and interpretation .....	45.76
Echocardiography		
Complete study - 1 dimension		
72220	- interpretation .....	40.82
72221	- procedure (IC) .....	17.92
Complete study - 2 dimensions		
72222	- interpretation .....	80.04
72223	- procedure (IC) .....	21.08
1 and 2 dimension study on same patient visit		
72224	- interpretation .....	92.13
72225	- procedure (IC) .....	26.00

RADIOLOGY

Code	Rate
<b>DIAGNOSTIC ULTRASOUND (Cont'd)</b>	
<b>Heart/Major Blood Vessel (Cont'd)</b>	
Limited study 1 or 2 dimensions for follow-up studies	
72226	- interpretation..... 18.76
72227	- procedure (IC) ..... 15.46
Doppler echocardiography	
72228	- interpretation..... 47.51
72229	- procedure (IC) ..... 20.21
Aorta only	
72230	- interpretation..... 52.19
72231	- procedure (IC) ..... 23.22
Vena cava only	
72232	- interpretation..... 52.19
72233	- procedure (IC) ..... 23.22
<b>Peripheral Vascular System</b>	
Extra-cranial vessel assessment (bilateral, carotid and/or subclavian and/or vertebral arteries)	
72240	- Doppler scan or B scan ..... 22.94
72241	- frequency analysis ..... 22.94
72242	- frequency analysis with Doppler scan..... 31.29
72243	- duplex scan, i.e. simultaneous real time, B-mode imaging and spectral analysis..... 56.37
Duplex Doppler assessment of hepatic and portal venous systems	
72244	- interpretation..... 14.79
72245	- procedure ..... 19.72
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..... 14.79
72247	- procedure ..... 19.72
Transcranial Doppler assessment	
72248	- interpretation..... 19.48
72249	- procedure ..... 26.06
Peripheral artery evaluation ( <u>not</u> to be billed routinely with 72241, 72242 or 72243)	
72250	- Doppler scan or B-scan ..... 18.98
72251	- frequency analysis ..... 15.69
72252	- frequency analysis with Doppler scan..... 26.08
72253	- duplex scan, i.e. simultaneous real time, B-mode imaging and spectral analysis..... 30.44
Venous evaluation - duplex scan i.e. simultaneous real time, B-mode imaging	
72254	- interpretation..... 18.48
72255	- procedure ..... 31.43
Duplex Doppler assessment of post-operative shunts	
72256	- interpretation..... 14.79
72257	- procedure ..... 19.72
Doppler assessment of intra-abdominal vessels	
72258	- interpretation..... 25.76
72259	- procedure ..... 22.36
<b>Thorax</b>	
Chest masses, pleural effusion - A and B-mode	
72340	- interpretation..... 36.50
72341	- procedure (IC) ..... 23.22
Ultrasonic thoracentesis	
72350	- procedure and interpretation..... 21.65
Breast masses - scan B-mode (per breast)	
72360	- interpretation..... 32.65
72361	- procedure (IC) ..... 33.96



## RADIOLOGY

Code		Rate
<b>DIAGNOSTIC ULTRASOUND (Cont'd)</b>		
<b>Abdomen and Retroperitoneum</b>		
	Abdominal scan, major (includes multiple organs and/or spaces)	
72400	- interpretation .....	51.74
72401	- procedure (IC) .....	60.83
	Abdominal scan, limited (e.g. single organ or follow-up study)	
72403	- interpretation .....	37.29
72404	- procedure (IC) .....	23.22
<b>Scrotum</b>		
	Testicular (1 or both) or scrotal scanning	
72450	- interpretation .....	43.10
72451	- procedure (IC) .....	23.22
<b>Obstetrics, Gynaecology and Pelvis</b>		
	Echography - Scan B-mode	
	Early pregnancy diagnosis	
72500	- interpretation .....	41.87
72501	- procedure (IC) .....	33.36
	Foetal age determination	
72510	- interpretation .....	25.76
72511	- procedure (IC) .....	21.44
	Placenta localization	
72520	- interpretation .....	25.76
72521	- procedure (IC) .....	22.36
	IUCD localization	
72530	- interpretation .....	25.76
72531	- procedure (IC) .....	22.36
	Pregnancy, complete	
72540	- interpretation .....	33.70
72541	- procedure (IC) .....	22.36
	Foetal assessment in - utero for physical condition of the fetus (requested by the specialist)	
72545	- interpretation and procedure .....	41.31
	Pelvic mass	
72570	- interpretation .....	41.86
72571	- procedure (IC) .....	22.36
	Endocavitary Scan	
72575	- interpretation .....	73.94
72576	- procedure .....	22.36
72578	Transvaginal sonohysterography, includes procedure, interpretation and introduction of saline or other intracavitary contrast media.....	112.02
	Ultrasonic amniocentesis	
72580	- interpretation and procedure .....	23.45

RADIOLOGY

Code		Rate
<b>DIAGNOSTIC ULTRASOUND (Cont'd)</b>		
<b>Extremities</b>		
	Extremities, per limb (excluding vascular study)	
72610	- interpretation.....	15.74
72611	- procedure (IC) .....	23.22
	Scan of popliteal space	
72620	- interpretation.....	21.90
72621	- procedure (IC) .....	23.22
<b>NOTES:</b>		
1. <i>A-mode - implies a one-dimensional ultrasonic measurement procedure.</i>		
2. <i>M-mode - implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures.</i>		
3. <i>Scan B-mode - implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display.</i>		
<b>THERAPEUTIC ULTRASOUND</b>		
72650	Occlusion of femoral or brachial pseudo-aneurysm under colour Doppler ultrasound guidance .....	136.55
<b>COMPUTED TOMOGRAPHY</b>		
<b>Head</b>		
73800	- without IV contrast .....	50.66
73801	- with IV contrast .....	75.94
73802	- with and without IV contrast.....	88.68
<b>Complex head</b>		
73805	- without IV contrast .....	75.94
73806	- with IV contrast .....	88.68
73807	- with and without IV contrast.....	101.28
<b>Neck</b>		
73810	- without IV contrast.....	50.66
73811	- with IV contrast .....	75.94
73812	- with and without IV contrast.....	88.68
<b>Thorax</b>		
73815	- without IV contrast .....	75.94
73816	- with IV contrast .....	88.68
73817	- with and without IV contrast.....	101.28
<b>Abdomen</b>		
73820	- without IV contrast .....	101.28
73821	- with IV contrast .....	113.88
73823	- with and without IV contrast.....	126.62
<b>Extremities (1 or more)</b>		
73825	- without IV contrast .....	50.66
73826	- with IV contrast .....	75.94
73827	- with and without IV contrast.....	88.68
<b>Spine(s)</b>		
73830	- without IV contrast .....	101.28
73831	- with IV contrast .....	113.88
73832	- with and without IV contrast.....	126.62
<b>Pelvis</b>		
73835	- without IV contrast .....	101.28
73836	- with IV contrast .....	113.88
73837	- with and without IV contrast.....	126.62

RADIOLOGY

Code		Rate
<b>MAGNETIC RESONANCE IMAGING</b>		
<b>Head</b>		
73850	- multislice SE (1 or 2 echos).....	94.92
73851	- multislice IR.....	61.82
73852	- repeat (another plane, different pulse sequence - max. 2).....	47.36
73853	- when gating is performed, (fee = <u>30%</u> of applicable imaging fee).....	IC
<b>Neck</b>		
73855	- multislice SE (1 or 2 echos).....	94.92
73856	- multislice IR.....	61.82
73857	- repeat (another plane, different pulse sequence - max. 2).....	47.36
<b>Thorax</b>		
73860	- multislice SE (1 or 2 echos).....	110.62
73861	- multislice IR.....	94.92
73862	- repeat (another plane, different pulse sequence - max. 2).....	55.26
73863	- when gating is performed, (fee = <u>30%</u> of applicable imaging fee).....	IC
<b>Abdomen</b>		
73865	- multislice SE (1 or 2 echos).....	110.62
73866	- multislice IR.....	94.92
73867	- repeat (another plane, different pulse sequence - max. 2).....	55.26
73868	- when gating is performed, (fee = <u>30%</u> of applicable imaging fee).....	IC
<b>Pelvis</b>		
73870	- multislice SE (1 or 2 echos).....	110.62
73871	- multislice IR.....	94.92
73872	- repeat (another plane, different pulse sequence - max. 2).....	55.26
<b>Extremity</b>		
73875	- multislice SE (1 or 2 echos).....	94.92
73876	- multislice IR.....	61.82
73877	- repeat (another plane, different pulse sequence - max. 2).....	47.36
<b>Spine</b>		
Spinal segments recognized are cervical, thoracic, and lumbo-sacral		
Limited spine -1 segment		
73880	- multislice SE (1 or 2 echoes).....	110.62
73881	- multislice IR.....	94.92
73882	- repeat (another plane, different pulse sequence - max 2).....	55.26
Intermediate spine - 2 adjoining segments		
73886	- multislice SE.....	128.92
73887	- multislice IR.....	145.76
73888	- repeat (another plane, different pulse sequence - max. 2).....	64.40
Complex spine - 2 or more non-adjoining or complete segments		
73891	- multislice SE.....	191.66
73892	- multislice IR.....	145.76
73893	- repeat (another plane, different pulse sequence - max. 2).....	95.41
73895	When gating of spine is performed, (fee = <u>30%</u> of applicable imaging fee).....	IC

**RADIOLOGY**

Code		Spec.	Anaes.
<b>INTERVENTIONAL RADIOLOGY</b>			
74100	Endovascular obliteration of cerebral aneurysms by any technique..	1901.39	I.C.
<b>NOTES:</b>			
<ol style="list-style-type: none"> <li>1. Includes all neurological exams done in association with the procedure, any diagnostic angiography performed at time of procedure, fluoroscopy and any other necessary imaging performed at the time of the procedure;</li> <li>2. Separate micro catheterization and stenting included if required;</li> <li>3. Multiple aneurysms paid as follows: 2<sup>nd</sup> at 50%, 3<sup>rd</sup> at 25% (to a maximum of three aneurysms);</li> <li>4. Radiological specialist assists are billable in Capacity "1" at 75% of the listed rate for code 74100 as per General Preamble;</li> </ol>			
74300	Percutaneous image guided radiofrequency ablation of solid tumor.....	575.00	
<b>NOTES:</b>			
<ol style="list-style-type: none"> <li>1. Payable only for non-resectable liver, kidney, lung tumours, colorectal metastases and osteoid osteoma;</li> <li>2. Payable to a maximum of 3 lesions treated at same session – 100% for first lesion, 50% for second and third lesion;</li> <li>3. Includes all imaging guidance by any method necessary to complete the procedure.</li> </ol>			
<b>DIAGNOSTIC BIOPSY</b>			
74520	Image-guided biopsy, any organ, by any radiographic technique.....	103.69	See biopsy codes

**IN-HOSPITAL DIAGNOSTIC AND THERAPEUTIC SERVICES**

Code		Rate
<b>ELECTROCARDIOGRAMS</b>		
56000	Electrocardiogram interpretation .....	7.95
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.....	60.05
<b>Continuous Ambulatory ECG Monitoring</b>		
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
<b>ELECTROMYOGRAPHY AND NERVE CONDUCTION</b>		
56500	Complete procedure, e.g. conduction studies on 2 or more nerves and EMG of multiple muscles; detailed study of neuromuscular transmission.....	164.59
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
<b>ELECTROENCEPHALOGRAPHY</b>		
57000	Electroencephalogram interpretation .....	41.16
57010	- with use of sleep inducing drugs and/or sleep deprivation .....	add 28.38
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
<b>SLEEP APNEA STUDIES</b>		
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
<b>EVOKE POTENTIAL STUDIES</b>		
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

**IN-HOSPITAL DIAGNOSTIC AND THERAPEUTIC SERVICES**

Code		Rate
<b>OPHTHALMOLOGY</b>		
57780	Ocular Coherence Tomography - interpretation, uni or bilateral.....	25.00
	<i><b>NOTE:</b> This fee code can only be claimed by Ophthalmologists 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.</i>	
57782	Corneal Pachymetry, uni or bilateral .....	2.50
	<i><b>NOTE:</b> 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.</i>	
<b>OBSTETRICS AND GYNECOLOGY</b>		
57700	Non-stress test - interpretation only.....	6.84
	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.....	41.87
57711	- procedure .....	33.36
	Nuchal translucency determination by MFM Specialist (once per pregnancy)	
57712	- interpretation.....	25.30
57713	- procedure .....	40.00
	<b>NOTE:</b> Routine screening of Nuchal translucency without biochemical markers in singleton pregnancies is not an insured service.	
	Placenta localization	
57714	- interpretation.....	25.76
57715	- procedure .....	22.36
	Transvaginal assessment of cervical length in pregnancy at increased risk for preterm birth by MFM Specialist	
57716	- interpretation.....	16.15
57717	- procedure .....	25.00
	<b>NOTE:</b> Routine screening of cervical length of pregnancy is not an insured service.	

## IN-HOSPITAL DIAGNOSTIC AND THERAPEUTIC SERVICES

Code		Rate
<b>OBSTETRICS AND GYNECOLOGY (Cont')</b>		
<b>Maternal Fetal Medicine (MFM) (Cont'd)</b>		
	Fetal anatomy scan by MFM Specialist	
57718	- interpretation .....	33.70
57719	- procedure .....	22.36
	Fetal Doppler evaluation of middle cerebral artery, and/or IVC and/or ductus venosus	
57720	- interpretation .....	31.60
57721	- procedure .....	32.90
	<b>NOTE:</b> 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 <sup>th</sup> percentile or twin-twin transfusion syndrome.	
	Fetal assessment in - utero for physical condition of the fetus	
57730	- interpretation and procedure .....	41.31
<b>ORGANIZED PAIN CLINIC</b>		
<b>Notes:</b>		
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	Epidural steroid injection.....	90.49
57802	Intercostal nerve block(s) (maximum 2 units).....	82.11
57804	Paravertebrae nerve block of thoracic and lumbar roots - each (maximum 4 units) .....	72.39
57806	Peripheral nerve block for chronic pain (maximum 2 units).....	72.39
57808	Cranial nerve/branch block for chronic pain (maximum 2 units).....	90.49
57810	Stellate ganglion block .....	90.49
57812	Intravenous sympathetic block by injection and infusion of Bretylium, Guanethidine and Reserpine ....	108.59
57814	Intravenous injection and infusion with lidocaine for the treatment of chronic pain .....	135.72
<b>OTOLARYNGOLOGY</b>		
57840	Laryngeal Videostroboscopy (procedure and interpretation).....	108.50

**IN-HOSPITAL DIAGNOSTIC AND THERAPEUTIC SERVICES**

**PULMONARY FUNCTION STUDIES**

The benefits for simple spirometry and standard lung mechanics represent the best of three recorded test results with or without bronchodilator.

The benefit for standard lung mechanics includes simple spirometry.

Vital capacity and flow volume loop cannot be claimed at the same time.

<b>Code</b>	<b>Rate</b>
58000 Simple spirometry, e.g., vital capacity, without permanent record by transducer equipment FVC, FEV, MVV (MBC), etc.....	1.61
Standard lung mechanics (with permanent record)	
58010 - Vital capacity, FEV, FEV/FVC .....	4.14
58015 - Repeat of 58010 after bronchodilator.....	1.67
58020 - 58010 plus MMEFR calculation.....	6.87
58025 - Repeat of 58020 after bronchodilator.....	2.67
58030 - MVV done together with 58010 or 58020.....	.81
58040 - Flow volume loop (FVC, FEV, FEV/FVC, V <sub>30</sub> , V <sub>25</sub> ).....	10.40
58050 - Repeat of 58040 after bronchodilator.....	3.67
Complex Lung Mechanics`	
58100 - Functional residual capacity by gas dilution method .....	10.67
58110 - Functional residual capacity by body plethysmography .....	10.67
58120 - Airways resistance by plethysmography or estimated using esophageal catheter.....	5.87
58130 Lung Compliance (pressure volume curve of the lung from TLC to FRC) .....	27.72
58140 Carbon monoxide diffusing capacity by steady state of rest.....	6.67
58150 Carbon monoxide diffusing capacity by single breath method.....	10.67
Pulmonary Function Response to O <sub>2</sub> and CO <sub>2</sub>	
58160 CO <sub>2</sub> ventilatory response.....	8.40
58170 O <sub>2</sub> ventilatory response (physician must be present) .....	12.54
Exercise Assessment - physician must be in attendance at all times	
58180 - Exercise diffusing capacity .....	10.06
58200 - Stage I: Graded exercise to maximum tolerance exercise (must include HR, ventilation and ECG at rest and at each workload: ECG monitored at least 5 minutes post exercise .....	31.85
58210 - Same as 58200 plus 58010, 58020 or 58040 before and after exercise.....	37.72
58220 - Stage II: Repeated steady state graded exercise (must include heart rate, ventilation, VO <sub>2</sub> , VCO <sub>2</sub> , BP, ECG endtidal and mixed venous CO <sub>2</sub> at rest, 3 levels of exercise and recovery).....	43.64
58230 - Stage III: Same as 58220 plus arterial blood gases, PH and bicarbonate or lactate.....	65.44
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 .....	15.54
Gas Analysis	
58270 - Arterial puncture for blood gas analysis .....	6.52
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.....	10.93
58320 - Mixed venous PCO <sub>2</sub> by the rebreathing method .....	2.53
58330 - O <sub>2</sub> saturation by oximeter (at rest and exercise) .....	6.52
58340 - Standard O <sub>2</sub> consumption and CO <sub>2</sub> production.....	5.52
58350 - Histamine or methylcholine threshold test.....	22.54



## DIAGNOSTIC AND THERAPEUTIC SERVICES

Code		G.P.	Spec. Spec.	Spec. Anaes.	G.P. Anaes.
54000	Visit for diagnostic and therapeutic service(s) only .....	4.60	4.60		
	<b>ALLERGY</b>				
54004	Acute desensitization; e.g., ATS penicillin .....	4.42	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 .....	11.77	13.08		
54016	Ophthalmic tests, (maximum 5 tests).....		.98		
54018	- quantitative .....		7.85		
54020	Passive transfer tests.....		28.34		
54022	Patch test, (maximum 50 tests) .....	1.55	1.71		
54026	Provocative testing - per session (limit of 6 sessions per patient).....		9.27		
54030	Repository therapy, per injection .....	67.53	75.00		
54032	Skin tests (maximum 50 tests/session) scratch or intradermal .....	2.09	2.32		

DIAGNOSTIC AND THERAPEUTIC SERVICES

Code		G.P.	Spec.	Spec. Anaes.	G.P. Anaes.
<b>ANAESTHESIOLOGY/THERAPEUTIC</b>					
54054	Hypothermia (therapeutic) induction and management.....			62.07	
<b>Nerve Blocks</b>					
1. Fees listed in the GP 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).....	44.75		49.70	
54068	24-hour monitoring of spinal narcotic given for analgesia .....			59.64	
54072	Gasserian Ganglion.....			55.10	
54073	Intrapleural 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 .....	30.78		34.20	
54080	Intercostal nerve root .....	30.78		34.20	
54082	- for each additional one .....			16.95	
54084	Intrathecal Spinal .....			75.10	
54086	Lumbar, sacral and coccygeal nerves .....			34.20	
54088	Mandibular .....	67.59		75.10	
54090	Mental branch of mandibular nerve .....			34.20	
54092	Occipital .....	30.78		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 or infiltration of tissues .....	53.70		59.64	
54108	Spheno-palatine ganglion.....			55.10	
54110	Splanchnic.....			55.10	
54112	Stellate ganglion .....			55.10	
54114	Supraorbital.....	30.78		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**

Code		G.P.	Spec. Spec.	G.P. Anaes.	G.P. Anaes.
<b>ANAESTHESIOLOGY/THERAPEUTIC (Cont'd)</b>					
<b>Nerve Blocks (Cont'd)</b>					
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	5
54134	Maintenance: claim 1 unit for each subsequent injection or ¼ hour of maintenance; maximum 12 units per day, per unit .....			1	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 .....	49.07	54.52		
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 .....	49.59	55.10		
<p><b><u>Patient controlled analgesia</u></b> 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> <p>Patient Controlled Analgesia (PCA) - for parenteral control of acute pain</p>					
54166	- initiation .....		47.75		
54167	- maintenance .....		10.61		

**DIAGNOSTIC AND THERAPEUTIC SERVICES**

Code	G.P.	Spec. Anaes.	G.P. Anaes.
<b>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.</b>			
Physician in chamber with patient, per dive <b>per patient</b>			
54180			<b>83.80</b>
54182			<b>41.90</b>
54184			<b>83.80</b>
Physician not in chamber with the patient, per dive <b>per patient</b>			
54188			<b>71.85</b>
54190			<b>35.90</b>
54192			<b>71.85</b>
<b>After Hours Hyperbaric Premiums</b>			
54194	Physician attendance commences between 6:00 p.m. and midnight or on Saturdays, Sundays or Statutory Holidays ..... add 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		
<b>Medical Assessments</b>			
54198	Initial medical assessment of a patient referred for HBOT.....		<b>121.00</b>
54199	Medical reassessment of a patient undergoing HBOT.....		<b>36.92</b>

*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**

Code		G.P.	Spec. Spec.	Spec. Anaes.	G.P. Anaes.
<b>CARDIOVASCULAR</b>					
<b>Vascular Cannulation</b>					
54202	Arterial Puncture .....	7.38	8.20		
54204	Cannulation of artery or central vein .....	37.14	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	4
54214	- measurement of cardiac output either thermal or dye dilution done at same setting (maximum 2 units payable) .....		28.66		
54218	Therapeutic venisection (phlebotomy) .....	5.30	5.89		
54220	Insertion of permanent feeding line under general anaesthesia (e.g. Hickman or Broviac catheter).....	135.76	150.84	4	4
54222	Surgical removal of permanent feeding line or catheter.....		36.34	4	4
54226	Anticoagulant Supervision - long term - per month .....	12.40	13.78		
<b>Blood Transfusions</b>					
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 .....	12.92	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		
<b>Cardioversion</b>					
54274	Cardioversion or defibrillation (maximum 3 per patient, per day).....	74.84	83.16	5	5
<b>Cardiac Catheterization</b>					
When more than one procedure is carried out by the same physician at one sitting, the additional procedures (codes 54280 to 54362) are to be charged at <u>50%</u> of the listed fees.					
<b>Hemodynamic/Flow/Metabolic Studies</b>					
Right heart					
54280	- pressures only .....		116.92	5	5
Left heart					
54284	- retrograde aortic .....		164.85	5	5
54286	- transseptal .....		201.70	5	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		
54294	Metabolic studies; e.g., coronary sinus lactate and pyruvate determinations .....		54.50		
54296	Exercise studies during catheterization .....		54.50		

## DIAGNOSTIC AND THERAPEUTIC SERVICES

Code		G.P.	Spec.	Spec. Anaes.	G.P. Anaes.
<b>CARDIOVASCULAR (Cont'd)</b>					
<b>Angiography</b>					
54310	Angiograms (any number of injections).....		77.23		
54312	By-pass graft angiogram (including internal mammary artery implant) - per graft injection.....		66.50		
54314	Selective coronary catheterization .....		186.59	5	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	5
54324	Coronary angioplasty stent, per stent.....add		67.00		
<b>Electrophysiologic Pacing, Mapping and Ablation</b>					
<b>Includes percutaneous access, insertion of catheters and electrodes, electrocardiograms, intracardiac echocardiograms and image guidance when rendered.</b>					
54330	- atrial <b>pacing and mapping</b> .....		317.08		
54332	- ventricular <b>pacing and mapping</b> .....		395.38		
54333	- <b>with the use of an advanced nonfluoroscopic computerized mapping and navigation system</b> ("advanced mapping system") and/or procedure duration >4 hours.....		690.25	10	10
<b>Note: 54333 is only eligible for payment when rendered with 54330 or 54332. See Preamble for additional terms and conditions.</b>					
54334	- catheter ablation therapy.....		333.99		
54336	- repeated.....		105.47		
54338	External cardiac pacing (temporary transthoracic) once per 24-hour period ( <b>Note: not to be claimed with CPR</b> ) .....		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		
Arrhythmias: Induction of arrhythmias to include programmed electrical stimulation, drug provocation and termination of arrhythmia, if necessary, once per patient per 24 hours. ( <b>Note: CPR not payable with these services</b> )					
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 endocardial electrodes .....		110.28	5	5
54352	Repositioning .....		44.88	5	5
54354	Implantation of pack .....		119.19	5	5
54356	Insertion of endocardial electrode and implantation of pack (includes insertion of temporary transvenous lead at same surgical procedure by same surgeon) .....		212.22	5	5
54358	Replacement of pack.....		103.93	5	5
54360	Intracardiac electrocardiography and/or atrial pacing.....		54.50		
54362	Atrio-ventricular sequential pacemaker with permanent atrial and ventricular endocardial electrodes.....		405.20	5	5
<b>Endomyocardial Biopsy</b>					
54366	Transvenous endomyocardial biopsy .....		99.19		
<b>Vasomotor Syncope Testing</b>					
54368	Tilt Table Testing of Vasomotor Syncope to include arterial cannulation, provocative and blocking drugs (physician must be continually present) .....		103.00		

## DIAGNOSTIC AND THERAPEUTIC SERVICES

Code		G.P.	Spec. Spec.	G.P. Anaes.	G.P. Anaes.
<b>CARDIOVASCULAR (Cont'd)</b>					
<b>Cardiography: (includes technical component)</b>					
54370	Apex.....				19.62
54374	Echo.....				24.53
54375	Saline study (including venipuncture) .....	9.45			10.83
54376	Insertion of oesophageal transducer.....	23.94			27.41
54377	Transoesophageal echocardiography.....				16.55
54378	Umbilical arterial catheterization - (including obtaining of blood sample) .....				26.16
<b>Electrocardiogram</b>					
54380	Office - technical component.....	8.22		9.13	
54382	- professional component .....	8.34		9.27	
54384	Home - technical component.....	10.66		11.84	
54386	- professional component .....	11.12		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..add				37.26
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.....				12.70
54416	- technical component.....				11.30
	Pacemaker pulse wave analysis including electrocardiography				
54418	- professional component.....				8.50
54420	- technical component.....				8.50
<b>Interrogation, Reprogramming of Automatic Implantable Defibrillator</b>					
54421	Interrogation of automatic implantable defibrillator.....				27.80
54422	Interrogation and reprogramming of automatic implantable defibrillator.....				45.21

## 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.

**DIAGNOSTIC AND THERAPEUTIC SERVICES**

Code		G.P.	Spec. Anaes.	G.P. Anaes.
<b>Vascular Laboratory Fees</b>				
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**

Code	G.P.	Spec. Spec.	G.P. Anaes.	G.P. Anaes.
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**DERMATOLOGY**

	Laser Treatment of Insured Vascular Lesions			
54430	First ½ hour or 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-laid spots, etc., it 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.
- (c) All congenital vascular lesions that present with recurrent bleeding, ulceration, or are complicated by functional defect (e.g. peri-orbital strawberry haemangioma) are insured.

**Insured Vascular Lesions**

1. Port Wine Stains - Bill using remarks code 26. Over the age of 18, only lesions on the face and neck are insured.
2. Strawberry haemangiomas - Bill using remarks code 27. Over the age of 18, lesions are insured only if a complication as listed above is present.
3. Blue Rubber Bleb Syndrome - Bill using remarks code 28. Over the age of 18, this familial condition usually presents in the elderly as painful bluish tumours. Treatment of all such haemangiomas is insured.
4. Angiofibromas of Tuberous Sclerosis - Bill using remarks code 29. Over the age of 18, insured when on the face and neck only.
5. Cherry Haemangiomas - Bill using remarks code 30. Over the age of 18, insured only if complications.
6. Haemangio-Lymphangiomas - Bill using remarks code 31. Over the age of 18, these large congenital tumours are insured only when complications are present, i.e. lymphatic vessel leakage, or as listed above.
7. Facial Telangiectasias - Bill using remarks code 32. Over the age of 18, these lesions are uninsured unless associated with the following:
  - (a) Lupus, Rendu-Osler-Weber Syndrome, CRST Syndrome (Calcinosis Curtis-Raynaud's Phenomena-Sclerodactyly-Telangiectasia).
  - (b) Rosaceous Telangiectasis, over the age of 18 are insured only when the major contributing factor is acne rosacea and not aging and/or sun damage.
8. Arterio-Venous Malformations - Bill using remarks code 33. Over the age of 18, lesions are insured only when complicated by soft tissue hypertrophy.

Any other lesions considered for laser treatment not covered by the specific or general guidelines in this section require preauthorization from the Director of Physicians Services or Assistant Medical Director of MCP.

**DIAGNOSTIC AND THERAPEUTIC SERVICES**

Code		G.P.	Spec.	Spec. Anaes.	G.P. Anaes.
<b>DIALYSIS:</b> team fees to include listed items. (This does not include preliminary investigation of the case)					
<b>Haemodialysis</b>					
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	6
54456	Medical component (included in the initial fee).....		426.83		
54458	Chronic .....		54.02		
<b>Management of cannula, shunt, or by pass-graft</b>					
Revision of Cannula or Scribner Shunt					
54460	- single.....		61.04	4	4
54462	- both .....		87.20	4	4
54464	De-clotting of Cannula or Scribner Shunt.....	44.15	53.46		
54465	Removal of cannula or AV shunt.....		72.00	4	4
54466	By-pass graft for haemodialysis - complete surgical care .....		290.54	7	7
<b>Peritoneal dialysis</b>					
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		
<b>Management of peritoneal cannula or catheter</b>					
54486	Insertion of peritoneal cannula by laparotomy - complete surgical care		112.28	6	6
54488	Insertion of Tenckhoff type peritoneal catheter - chronic - by trocar....		49.60	4	4
54490	Removal of Tenckhoff type peritoneal catheter .....		27.03	4	4
<b>Home Dialysis</b>					
54492	Monthly retainer for administration and supervision .....		98.10		
Claim date <u>must</u> be last date of each completed month of supervision.					
<b>Satellite Haemodialysis</b>					
54494	Weekly fee for administration and supervision of Satellite Haemodialysis patients, per patient.....		37.28		
<b>NOTES:</b>					
1. Fee code 54494 is the benefit for managing chronic haemodialysis where the patient undergoes dialysis at a DOHCS 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 .....		54.02		

## DIAGNOSTIC AND THERAPEUTIC SERVICES

Code		G.P.	Spec. Spec.	G.P. Anaes.	G.P. Anaes.
<b>ENDOCRINOLOGY AND METABOLISM</b>					
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 .....	10.79			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
<b>GASTROENTEROLOGY</b>					
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 .....	5.40			6.54
54572	- therapeutic .....	18.64			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 .....				35.00
<b>54586</b>	<b>Capsule endoscopy .....</b>				<b>342.10</b>

**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**

Code		G.P.	Spec.	Spec. Anaes.	G.P. Anaes.
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**GENERAL PRACTICE**

	Methadone Maintenance Therapy - Monthly stipend for overseeing patients on methadone for opioid dependency.				
54590	First 3 months - per patient, once per month (lifetime maximum ..of 3 months) .....	40.00			
54592	Second 3 months - per patient, once per month (lifetime maximum of 3 months) .....	30.00			
54594	Thereafter - per patient, once per month.....	20.00			

**Notes:**

1. Entitlement to these monthly stipends is limited to physicians who:
  - (a) have a current valid licence to prescribe methadone for addiction;
  - (b) are actively supervising the patient's continuing use of methadone.
2. Only one physician will be paid the monthly stipend. Change of physician does not affect level of payment.
3. Visits for each patient contact would be paid as at present.
4. Not eligible for premiums or surcharges.
5. No restarts in the payment program, i.e. if the patient leaves the program and then at a later date re-enters the program, his or her payment would resume at the same level as when he/she opted out.
6. This payment stops when the patient stops taking methadone.

**GYNECOLOGY**

54600	Artificial insemination.....	15.48	17.20		
54606	Huhner's test.....		8.18		
54614	Papanicolaou smear (no charge if done as part of a consultation, repeat consultation, general or specific assessment or routine post-natal visit .....	11.00	5.91		
54616	Vaginal insufflation .....	4.42	4.91		

**DIAGNOSTIC AND THERAPEUTIC SERVICES**

Code		G.P.	Spec. Spec.	Spec. Anaes.	G.P. Anaes.
<b>INJECTIONS OR INFUSIONS</b>					
Lateral discography					
54626	- lumbosacral disc as first disc .....		76.68	4	4
54628	- any other disc as first disc.....		40.06	4	4
54630	- second and subsequent discs, each .....		20.60		
Injection of chemonucleolysis					
54632	- initial injection .....	10.31	11.45		
54634	- any subsequent injection at other levels, each .....		5.72		
54636	Injection of extensive keloids .....	18.45	20.50		
54638	- under general anaesthesia .....		37.50	4	4
54640	BCG inoculation, including tuberculin tests.....	4.91	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.....	16.80	18.67		
54646	- each additional site or area (maximum 8 injections per visit). add	4.91	5.45		
54650	Influenza immunization of target population; visit fee and/or fee code 54000 not payable in addition .....	17.16	14.66		
Botulinum Toxin Injection for Dystonia					
54652	- single muscle .....		75.00		
54654	- more than 1 muscle .....		135.00		
Intradermal, intramuscular or subcutaneous - with visit - first injection					
54656	- each additional injection .....	1.18	1.31	No Charge	
Intradermal, intramuscular or subcutaneous sole reason					
54658	- first injection.....	2.36	2.62		
54656	- each additional injection .....	1.18	1.31		
54660	Intralesional infiltration (1 or more lesions) .....	13.43	14.92		
<b>Intravenous</b>					
No fee is payable for injections into an established IV apparatus.					
54664	Newborn or infant .....	9.60	10.67		
54666	- scalp vein.....	13.82	15.36		
54668	- cut down .....	18.23	20.26		
54670	Child, adolescent or adult .....	3.44	3.82		
54674	- cut down .....	15.70	19.01		
<b>Chemotherapy</b> (marrow suppressant) - 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.					
54688	- single injection (for agents other than adriamycin, cisplatin, bleomycin, high dose methotrexate, or similarly toxic agents)...	12.51	13.90		
54690	- each additional injection (other than above drugs)..... add	6.30	7.00		

**DIAGNOSTIC AND THERAPEUTIC SERVICES**

Code		G.P.	Spec. Anaes.	G.P. Anaes.
<b>INJECTIONS OR INFUSIONS (Cont'd)</b>				
<b>Intravenous (Cont'd)</b>				
<b>Chemotherapy</b> 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 and establishment of intravenous)				
54692	- single agent intravenous chemotherapy i.e. adriamycin, cisplatin, bleomycin or similarly toxic agents.....	42.48	47.20	
54694	- multiple agent intravenous chemotherapy including at least one of either adriamycin, cisplatin, bleomycin or similarly toxic agents	56.84	63.15	
54696	- special single agent chemotherapy utilizing either high-dose methotrexate with folinic acid rescue - methotrexate given in a dose of greater than 1 g/m <sup>2</sup> or high dose of cisplatin greater than 75 mg/m <sup>2</sup> given concurrently with hydration and osmotic diuresis.....	80.60	89.55	
54700	Supervision of chemotherapy - monthly .....	10.22	11.35	
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 .....	4.91	5.45	
54712	- two or more injections (unilateral or bilateral).....	6.87	7.63	

**DIAGNOSTIC AND THERAPEUTIC SERVICES**

Code	G.P.	Spec.	Spec. Anaes.	G.P. Anaes.
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**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 .....	add		11.45
54808	- inserting subtemporal needle electrodes .....	add		11.45
54810	- attendance and supervision of ECG during major surgery .....			114.45
54816	- tensilon testing.....			18.00
54820	Amyltal test - bilateral - supervision and coordination of tests .....			62.95

**OPHTHALMOLOGY**

Contact lens fitting is not 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 *must* 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 .....	72.72		80.80
	<b>Note:</b> Fee code 54000 will not apply for fee code 54860 to 54896			
54860	Intravenous fluorescein angiography - professional and technical component.....			52.20
54864	Glaucoma provocative tests, including water drinking tests.....			17.44
54868	Ophthalmodynamometry .....			5.45
54870	Orthoptics (assessment or treatment).....			4.36
	Radioactive phosphorous examination			
54872	- anterior approach .....			28.89
54874	- posterior approach.....			57.77
54876	Sonography .....			42.67
54878	Static perimetry (uni or bilateral) .....			40.03
54880	Tonography (to include tonometry) .....			12.26
54882	- with water .....			17.44
54884	Tonometry (uni or bilateral).....	4.14		4.60
	(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 electromyographic control, per muscle .....			75.00

**DIAGNOSTIC AND THERAPEUTIC SERVICES**

Code	G.P.	Spec.	G.P. Anaes.	G.P. Anaes.
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**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.*



**DIAGNOSTIC AND THERAPEUTIC SERVICES**

Code		G.P.	Spec. Spec.	Spec. Anaes.	G.P. Anaes.
<b>OTOLARYNGOLOGY</b>					
54900	Particle repositioning manoeuvre for benign paroxysmal positional vertigo.....	17.54	19.49		
<b>Audiometric tests</b>					
Fee code 54000 will <u>not</u> apply for fee codes 54904 to 54910					
Pure tone air and bone conduction					
54904	- technical component.....	6.26	6.95		
54906	- professional component.....	4.05	4.50		
54908	- technical component with speech tests .....		8.75		
54910	- professional component with speech tests .....		11.93		
Impedance audiometry					
54914	- technical component.....	4.20	4.67		
54916	- professional component.....	7.35	8.17		
Advanced testing (may include recruitment sisi, tone decay, malingering, Bekesy test) (per test to a maximum of 2 tests)					
54922	- technical component .....		6.45		
54924	- professional component.....		5.00		
Hearing aid evaluation, including pure tone air and bone conduction and speech tests					
54930	- technical component.....		3.00		
54932	- professional component.....		2.45		
Cortical audiometry					
54938	- technical component.....		28.20	3	3
54940	- professional component.....		15.40		
<b>Vestibular function tests</b>					
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					
54958	- technical component.....		14.79		
54960	- professional component		14.10		
Electrogustometry					
54962	- professional component.....		9.27		

**DIAGNOSTIC AND THERAPEUTIC SERVICES**

Code		G.P.	Spec.	Spec. Anaes.	G.P. Anaes.
<b>PHYSICAL MEDICINE</b>					
54970	Nerve stimulation .....		22.89		
<b>Therapeutic Procedures</b>					
54976	Manipulation - major joint.....	7.16		7.96	
54978	- minor joint.....	3.53		3.92	
54980	Miscellaneous therapeutic procedures not exceeding one hour as listed below .....	4.50		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				
54982	Thermography of area (e.g. hand, foot or large joint) 1 or more areas - technical component .....			13.00	
54984	- professional component .....			6.50	

**DIAGNOSTIC AND THERAPEUTIC SERVICES**

Code		G.P.	Spec.	Spec. Anaes.	G.P. Anaes.
<b>PSYCHIATRY</b>					
54990	ECT..... 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)		74.98	3	3
<b>UROLOGY</b>					
55024	Cystometrogram and/or voiding pressure studies (micturition studies)		56.72		
55034	Prostatic massage .....	5.20	5.78		
55036	Penile pressure recordings - 2 or more pressures .....	8.68	9.64		
<b>VENIPUNCTURE</b>					
55040	Newborn or infant .....	4.91	5.45		
55042	- scalp vein.....		10.57		
55044	Child, adolescent or adult .....	4.73	5.26		
55046	Therapeutic venisection.....	5.89	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.

**DIAGNOSTIC AND THERAPEUTIC SERVICES**

**CLINICAL PROCEDURES 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:

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

**DIAGNOSTIC AND THERAPEUTIC SERVICES**

**PULMONARY FUNCTION STUDIES**

These fees are payable by MCP only when services are rendered outside of hospital.

The fee of pulmonary function examination includes the supplying of equipment, premises and technical services; responsibility for quality control and technical training, interpretation of the results of tests, and consultation between the physician responsible for tests and the referring doctor concerning the results of the tests.

Fee code 54000 is not payable in addition to these procedures.

Code		G.P.	Spec.
Standard Measurements			
55200	Vital capacity and subdivisions (IC, ERV) .....		4.58
55202	- plus resting ventilation and oxygen consumption .....		6.98
55204	Functional residual capacity and/or residual volume .....		13.95
55210	Timed vital capacity (FEV <sub>0.5</sub> , FEV <sub>0.75</sub> , FEV <sub>1</sub> , peak flow, MMFR, etc.....	6.87	7.63
55212	Maximum voluntary ventilation.....		5.78
Exercise Tests			
55232	Simple progressive exercise tests at several work-loads, with measurement of heart rate by ECG and of ventilation .....		34.88
Arterial Blood Gas Tests			
55252	Blood analysis for pH, PO <sub>2</sub> , PCO <sub>2</sub> , HCO <sub>3</sub> , with interpretation .....		11.45
55254	- plus oxygen saturation with interpretation .....		11.45
55256	- plus expired gas analysis and computation of A-a and/or a-A gas tension differences .....		51.23
55258	Exercise in a steady rate at two or more workloads with heart rate measurements by ECG, and ventilation VO <sub>2</sub> , VCO <sub>2</sub> , entidal and mixed venous PCO <sub>2</sub> , plus arterial blood gas analysis .....		87.20
55260	Blood analysis for oxygen content and capacity .....		19.62
Oximetry (ear)			
55264	- Change of arterial oxygen saturation on exercise .....		5.45

**CRITICAL CARE**

**NEONATAL INTENSIVE CARE**

Code		G.P.	Spec.
<b>Level A:</b> Infant in Neonatal Intensive Care Unit maintained by artificial ventilation (all modalities) and with full invasive monitoring and parenteral alimentation.			
51730	- first day .....	344.56	382.84
51732	- 2 <sup>nd</sup> day to 10 <sup>th</sup> day (inclusive), per diem .....	172.22	191.35
51734	- 11 <sup>th</sup> day onwards, per diem .....	86.11	95.68
<b>Level B:</b> Infant in Neonatal Intensive Care Unit requiring full monitoring both invasive and non-invasive with O <sub>2</sub> administration and IV therapy but without Ventilatory Support			
51738	- first day .....	222.78	247.53
51740	- 2 <sup>nd</sup> day onwards, per diem.....	63.00	70.00
<b>Level C:</b> Infant in Neonatal Intensive Care Unit requiring O <sub>2</sub> administration and non-invasive monitoring and gavage feeding			
51744	- first day .....	149.39	165.99
51746	- 2 <sup>nd</sup> day onwards, per diem.....	31.16	34.62
<b>Concurrent Care (NICU)</b>			
51790	Physician rendering care concurrently with the physician in-charge, per diem.....	22.62	25.14

**CRITICAL CARE**

**ICU AND CCU**

Code		G.P.	Spec
<b>Comprehensive Care:</b> 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 .....	271.13	301.26
51752	- 2 <sup>nd</sup> day to 10 <sup>th</sup> day, per diem .....	135.57	150.62
51754	- 11 <sup>th</sup> day onwards, per diem.....	67.78	75.32
<b>Critical Care:</b> 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 .....	184.11	204.57
51758	- 2 <sup>nd</sup> to 10 <sup>th</sup> day, per diem.....	92.06	102.29
51760	- 11 <sup>th</sup> day onwards, per diem.....	46.03	51.15
<b>Observatory Care:</b> ICU or CCU patient without invasive monitoring and without assisted ventilation			
51766	- first day .....	104.42	116.02
51768	- 2 <sup>nd</sup> day to 10 <sup>th</sup> day, per diem.....	52.21	58.01
51770	- 11 <sup>th</sup> day onwards, per diem.....	26.10	29.00
<b>Ventilatory Support:</b> 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 .....	87.01	96.68
51776	- 2 <sup>nd</sup> day to 10 <sup>th</sup> day, per diem.....	43.51	48.34
51778	-11 <sup>th</sup> day onwards, per diem.....	21.75	24.17
<b>Concurrent Care (ICU, CCU)</b>			
51790	Physician rendering care concurrently with the physician in-charge, per diem .....	22.62	25.14

**CRITICAL CARE**

**Code** **G.P.** **Spec**

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**CARDIO-PULMONARY RESUSCITATION**

**Cardiac Arrest**

51820	First unit (0 to 15 minutes or any portion thereof).....	<b>55.54</b>	<b>61.70</b>
51822	Subsequent units (each subsequent 15 minutes or part thereof) .....	<b>25.59</b>	<b>28.44</b>

- (1) *Units are timed from the onset of the arrest and the presence of the physician.*
- (2) *A maximum of three physicians will be paid for each time unit*
- (3) *The unit fees include all necessary resuscitative measures, e.g., defibrillation, cardioversion, cut-downs, etc.*

**PROVINCIAL PERINATAL HIGH RISK UNIT**

**Physician in Charge**

51920	- first day .....	<b>79.00</b>	
51922	- subsequent days .....		<b>36.55</b>

**Concurrent Care (ICU, CCU, Provincial Perinatal High Risk Unit)**

51790	Physician rendering care concurrently with the physician-in-charge, per diem .....	<b>22.62</b>	<b>25.14</b>
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**SURGICAL PROCEDURES**  
**OPERATIONS ON ORGANS OF SPECIAL SENSES**  
**OPERATIONS ON THE EYE**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
98800	Examination and unlisted minor procedures under general anaesthetic, when <u>sole</u> procedure (IOP) .....			<b>70.22</b>	4	4
<b>EYEBALL</b>						
<b>Excision</b>						
98810	Enucleation, donor eye, post-mortem (1 or both).....			<b>129.50</b>		
<b>Repair</b>						
98820	Removal of intraocular foreign body .....		32.68	<b>572.54</b>	6	6
98822	- non-magnetic-posterior segment.....		32.68	<b>584.65</b>	6	6
Penetrating wound						
98824	- with prolapse of intraocular tissue .....		32.68	<b>303.68</b>	6	6
98826	- without prolapse of intraocular tissue .....		32.68	<b>243.16</b>	6	6
<b>CORNEA</b>						
<b>Incision</b>						
98830	Paracentesis (IOP) .....			<b>51.55</b>	4	4
Removal embedded foreign body (IOP)						
<i>Note: <u>Not</u> to be claimed for the routine removal of sutures within 42 days of procedure.</i>						
98832	- local anaesthetic - 1 foreign body.....	<b>32.42</b>		<b>36.02</b>		
98834	- 2 or more foreign bodies.....			IC		
98836	- general anaesthetic.....			<b>72.82</b>	4	4
Chelation of band keratopathy with EDTA (IOP)						
98838	- local anaesthetic .....			<b>25.75</b>		
98840	- general anaesthetic.....			<b>72.82</b>	4	4
<b>Excision</b>						
98850	Pterygium - simple (unilateral) .....			<b>136.32</b>	4	4
98852	- with partial keratectomy.....		32.68	<b>372.50</b>	4	4
98854	- with lamellar graft .....		32.68	<b>445.52</b>	8	8
98856	- with autogenous conjunctival transplant.....add			<b>79.52</b>		
98858	- with mucous membrane graft.....add			<b>111.65</b>		
98860	Keratectomy.....		32.68	<b>303.68</b>	4	4
Excision of dermoid						
98862	- with partial keratectomy.....			<b>303.68</b>	4	4
98864	- with lamellar graft .....		32.68	<b>445.52</b>	8	8
Cauterization of ulcer (IOP)						
98866	- local anaesthetic .....			<b>25.75</b>		
98868	- general anaesthetic.....			<b>72.82</b>	4	4
<b>Replacement</b>						
Corneal transplant						
98880	- penetrating .....		32.68	<b>682.30</b>	8	8
98882	- with artificial prosthesis .....			<b>51.55</b>		
98884	- lamellar.....		32.68	<b>445.52</b>	8	8
98886	Division of iris to cornea.....			<b>158.93</b>	4	4

**SURGICAL PROCEDURES**

**OPERATIONS ON ORGANS OF SPECIAL SENSES  
OPERATIONS ON THE EYE**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>SCLERA</b>						
<b>Incision</b>						
98890	Sclerotomy, posterior .....			<b>163.69</b>	4	4
98892	Anterior chamber - open evacuation of clot.....		32.68	<b>363.40</b>	6	6
<b>IRIS AND CILIARY BODY</b>						
98900	Laser iridotomy.....		32.68	<b>252.97</b>	4	4
98902	Laser angle surgery.....			<b>390.88</b>	4	4
98904	Iridectomy - surgical - when sole procedure.....		32.68	<b>303.68</b>	4	4
98906	Glaucoma filtering procedures .....		32.68	<b>571.45</b>	6	6
98908	- with intraocular implant of seton .....			<b>78.70</b>		
98910	Extraocular glaucoma procedures.....		32.68	<b>180.02</b>	4	4
98912	Ciliary body reattachment.....		32.68	<b>498.31</b>	8	8
<b>CRYSTALLINE LENS</b>						
<b>Incision</b>						
98920	Needling (discission) - primary or subsequent .....			<b>158.93</b>	5	5
98922	Capsulotomy (any method) .....		32.68	<b>285.58</b>	4	4
<b>Excision</b>						
Cataract						
98930	- all types of, by any procedure.....		32.68	<b>473.09</b>	8	8
98932	- dislocated lens extraction .....		32.68	<b>597.98</b>	6	6
98934	- insertion of intraocular lens.....			<b>101.38</b>		
98936	Fixation of intraocular lens (McCannell suture procedure)		32.68	<b>263.76</b>	6	6
98938	Excision of secondary membrane with corneal section following cataract extraction.....		32.68	<b>259.05</b>	6	6
98940	Removal of intraocular lens.....		32.68	<b>309.31</b>	6	6
98942	Repositioning, surgical of dislocated intraocular lens.....			<b>158.93</b>	4	4
98946	Insertion of secondary intraocular lens.....		32.68	<b>303.68</b>	8	8
<b>VITREOUS</b>						
98950	Vitrectomy by infusion suction cutter technique .....		32.68	<b>1264.79</b>	8	8
98952	- with transscleral retinal suturing.....			<b>210.54</b>		
98954	Vitreous aspiration, posterior with needle for culture and/or injection of medication, with or without cryopexy		32.68	<b>232.90</b>	5	5
98956	Anterior vitrectomy (planned) when done in conjunction with another intraocular procedure.....			<b>88.07</b>		
98958	Preretinal membrane peeling or segmentation to include posterior vitrectomy and coagulation .....		32.68	<b>1724.39</b>	8	8
98960	Vitreous exchange (air, gas or artificial vitreous substance) - add to vitrectomy.....			<b>120.31</b>		

**SURGICAL PROCEDURES**  
**OPERATIONS ON ORGANS OF SPECIAL SENSES**  
**OPERATIONS ON THE EYE**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>RETINA</b>						
98970	Reattachment of retina and choroid by diathermy, photocoagulation or cryopexy as initial procedure.....		49.02	<b>459.55</b>	6	6
98972	Scleral resection or buckling procedure .....					
	- with or without diathermy, photocoagulation or cryopexy, primary or subsequent procedure.....		49.02	<b>1554.70</b>	6	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 .....		49.02	<b>1123.80</b>	6	6
98976	Removal of scleral implant.....			<b>255.07</b>	4	4
98978	Photocoagulation - 1 eye .....			<b>297.20</b>	6	6
98980	Cryopexy - extraocular or subconjunctival - 1 eye .....			<b>216.03</b>	6	6
<b>EXTRAOCULAR MUSCLES</b>						
<b>Repair</b>						
Strabismus procedures						
98990	- 1 muscle, 1 or both eyes .....		24.51	<b>365.56</b>	5	5
98992	- 2 muscles, 1 or both eyes .....		24.51	<b>365.56</b>	5	5
98994	- 3 or more muscles, 1 or both eyes .....		24.51	<b>405.16</b>	5	5
98996	- for adjustable suture..... add			<b>80.76</b>		
98998	Repeat strabismus procedure (more than 2 previous repairs by different surgeon)..... add			<b>121.60</b>		
<b>ORBIT</b>						
<b>Incision</b>						
99010	Drainage of abscess .....			<b>195.06</b>	6	6
<b>Excision</b>						
99020	Enucleation, with or without primary implant.....		32.68	<b>362.68</b>	4	4
99022	Evisceration, with or without primary implant.....		32.68	<b>362.68</b>	4	4
99024	Exenteration.....		32.68	<b>292.11</b>	6	6
99026	- with major plastic repair..... add			<b>292.11</b>		
99028	Secondary orbital implant .....		32.68	<b>366.87</b>	4	4
99030	Tumour or foreign body - anterior route.....		32.68	<b>303.68</b>	6	6
99032	- posterior exposure .....		32.68	<b>506.54</b>	6	6
99034	Biopsy - anterior .....			<b>158.93</b>	4	4
99036	- posterior exposure.....			<b>303.68</b>	4	4
99038	Lateral orbitotomy (Kronlein).....		24.51	<b>417.60</b>	6	6
99040	Decompression - 2 walls.....		32.68	<b>486.30</b>	6	6
99042	- 3 walls.....		32.68	<b>567.12</b>	6	6

## SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES  
OPERATIONS ON THE EYE

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>ORBIT (Cont'd)</b>						
<b>Reconstruction</b>						
99050	Dermis fat graft - immediately following enucleation .....			<b>187.28</b>		
99052	- delayed.....		32.68	<b>506.97</b>	6	6
99054	Fornix reconstruction.....			<b>243.16</b>	4	4
99056	- with mucous membrane graft .....			<b>316.66</b>	4	4
99058	- with autogenous conjunctival transplant .....			<b>79.52</b>		
Free mucous membrane graft						
99060	- full thickness .....			<b>219.08</b>	4	4
99062	- split thickness .....			<b>292.11</b>	4	4
99064	Alloplastic volume replacement.....			<b>405.16</b>	4	4
<b>EYELIDS</b>						
<b>Incision</b>						
Drainage of abscess (IOP)						
99070	- local anaesthetic.....	<b>36.32</b>		<b>40.35</b>		
99072	- general anaesthetic .....			<b>80.76</b>	4	4
<b>Excision</b>						
<b>Verrucae, papilloma, keratosis, etc. (IOP) - see Skin and Subcutaneous Tissue-Integumentary System also Lid Tumours or Unlisted Plastic Procedures</b>						
Chalazion - single or multiple (IOP)						
99080	- local anaesthetic.....	<b>36.32</b>		<b>40.35</b>		
99082	- general anaesthetic .....			<b>80.76</b>	4	4
Epilation						
99084	- by hyfrecator, electrolysis (IOP).....	<b>23.17</b>		<b>25.75</b>	4	4
99086	- by cryopexy .....			<b>64.91</b>	4	4
<b>Suture</b>						
99090	Tarsorrhaphy .....			<b>109.59</b>	4	4
99092	Double adhesion .....			<b>158.93</b>	4	4
<b>Repair</b>						
99100	Ptosis		32.68	<b>308.01</b>	4	4
99102	- repeat or second repair.....		32.68	<b>386.67</b>	6	6
99104	Distichiasis - unilateral.....		32.68	<b>238.01</b>	4	4
99106	Trichiasis, repair by tarsal transplantation .....		32.68	<b>238.01</b>	4	4
99108	Entropion, other than Zeigler puncture.....		32.68	<b>301.21</b>	4	4
99110	- repeat by second surgeon .....			<b>51.55</b>		
99112	- with mucous membrane graft .....			<b>111.65</b>		
99114	Ectropion, other than Zeigler puncture		32.68	<b>281.42</b>	4	4
99116	- repeat by second surgeon .....			<b>51.55</b>		
	- with skin graft, see Plastic Surgery Procedures - Integumentary System					

## SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES  
OPERATIONS ON THE EYE

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>EYELIDS (Cont'd)</b>						
<b>Repair (Cont'd)</b>						
99120	Zeigler punctures (for entropion/ectropion) (IOP) .....			25.75	4	4
99122	Laceration - full thickness .....			128.85	4	4
99124	- including lid margin.....			259.05	4	4
99126	Laceration of eyelid including levator palpebrae superioris with ptosis.....		32.68	324.78	4	4
Blepharoplasty						
99128	- excision of skin, with/without partial excision of the orbicularis oculi muscle - 1 lid.....			81.58	4	4
99130	- plus removal of orbital fat and/or lid fold reconstruction - 1 lid .....		32.68	202.32	4	4
99132	Lid lengthening procedure .....		32.68	283.56	4	4
99134	- with scleral graft .....			79.52		
99136	Primary closure of full thickness lid defect .....		32.68	263.76	4	4
99138	- with cantholysis .....			52.36		
99140	- with releasing rotation flap including cantholysis..add			87.63		
99142	Transconjunctival flap and skin graft (Hughes).....		32.68	476.90	6	6
99144	- second stage.....			106.56	4	4
99146	Lower or upper eyelid bridge flap.....		32.68	476.90	6	6
99148	- second stage.....			106.56	4	4
99150	Temporal rotation flap.....		32.68	506.97	6	6
99152	- with free posterior lamellar graft.....add			171.81		
99154	Free tarsal, scleral or cartilage graft with local skin mobilization .....		49.02	527.53	8	8
99156	Free composite eyelid graft.....		49.02	527.53	8	8
99158	Medial canthoplasty (skin and muscle) .....		32.68	253.49	4	4
Medial canthal tendon						
99160	- tendon repair only.....		32.68	263.76	4	4
99162	- fixating to bone.....		32.68	405.60	6	6
99164	- when done in conjunction with another procedure			150.38		
Lateral canthal surgery						
99166	Canthotomy - <u>not</u> to be claimed with 98930, 98932.....			50.68	4	4
99168	Cantholysis - when primary procedure.....			105.70	4	4
99170	Lateral canthopexy .....			200.14	4	4
99172	- when done in conjunction with another procedure .....add			100.51		
<b>CONJUNCTIVA</b>						
Removal of foreign body		VF		VF		
<b>Excision</b>						
99190	Peritomy (Gunderson conjunctival flap).....			109.59	4	4
99192	Biopsy (IOP) .....			25.75	4	4

**SURGICAL PROCEDURES**

**OPERATIONS ON ORGANS OF SPECIAL SENSES  
OPERATIONS ON THE EYE**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>CONJUNCTIVA (Cont'd)</b>						
<b>Repair</b>						
99200	Excision of conjunctival lesion .....			<b>79.52</b>	4	4
99202	- with mucous membrane graft .....			<b>111.65</b>		
99204	- with autogenous conjunctival transplant .....			<b>79.52</b>		
<b>LACRIMAL TRACT</b>						
<b>Incision</b>						
99210	Dacryocystotomy - general anaesthetic (IOP) .....			<b>51.55</b>	4	4
99212	Three "Snip" punctum procedure (IOP) .....			<b>64.48</b>	4	4
<b>Excision</b>						
99220	Dacryocystectomy .....		32.68	<b>250.89</b>	4	4
<b>Repair</b>						
99230	Lacerated canaliculus - immediate repair .....		32.68	<b>208.81</b>	4	4
99232	- delayed repair .....		32.68	<b>405.16</b>	5	5
99234	Dacryocystorhinostomy .....		40.85	<b>542.88</b>	5	5
99236	- repeat procedure by second surgeon .....			<b>85.90</b>		
99238	- with lacrimal by-pass procedure (e.g., Lester Jones) or canalicular reconstruction .....			<b>79.52</b>		
99240	Lacrimal by-pass procedure (e.g., Lester Jones) - when sole procedure .....			<b>178.73</b>	4	4
<b>Manipulation</b>						
99250	Irrigation of nasolacrimal system - uni or bilateral .....			<b>20.66</b>		
Probing and dilation of duct - initial or repeat						
99252	- local anaesthetic - unilateral .....			<b>22.28</b>		
99254	- general anaesthetic - uni or bilateral .....			<b>79.52</b>	4	4
99256	- with insertion of inlying tube or filament .....			<b>158.06</b>	4	4
99258	Reinsertion of Lester Jones tube .....			<b>51.55</b>		

**SURGICAL PROCEDURES**  
**OPERATIONS ON ORGANS OF SPECIAL SENSES**  
**OPERATIONS ON THE EAR**

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>EXTERNAL EAR</b>					
<b>Endoscopy</b>					
99302	VF		VF		
99304				28.34	4
99306				125.35	4
99308				125.35	4
99310				17.44	4
99312				25.55	4
				48.45	4
<b>NOTE:</b> "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.					
<b>Incision</b>					
99320				24.60	4
99326				83.93	4
99328				167.86	5
<b>Excision</b>					
99330				24.60	
99332				48.45	4
99338				83.93	4
99340				106.82	4
99342				187.95	4
99344				235.40	4
99346				171.13	5
99348				29.60	
99350				185.90	5
<b>Repair</b>					
<b>Microtia</b>					
99360		40.85	199.70	5	5
99362		40.85	314.50	5	5
99364					
99366				40.85	269.11
					5
99368				40.85	348.80
					5
				212.30	5
<b>Note:</b> 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		40.85	290.16	5	5
99374				197.54	1
99376				390.31	2

## SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES  
OPERATIONS ON THE EAR

Code	G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>MIDDLE EAR</b>					
<b>Introduction (IOP)</b>					
Eustachian Catheterization					
99380				5.45	
99382				21.80	4 4
				VF	
99383				150.00	
<b>Insufflation of eustachian tube.....</b>					
<b>Intratympanic injections.....</b>					
<b>Incision (IOP)</b>					
Myringotomy, to include aspiration when indicated					
99390				40.10	
99392				38.80	
99394				28.34	4 4
99396				74.14	4 4
99398				11.45	4 4
<b>Excision</b>					
Mastoidectomy					
- simple					
99410		32.68	328.50	6	6
99412		32.68	328.50	6	6
99414		32.68	489.80	7	7
99416		32.68	526.45	7	7
99420			103.86		
99422			83.28		
<b>Repair</b>					
99430		32.68	198.90	5	5
99432		49.02	651.23	7	7
99440		32.60	415.49	7	7
99442		49.02	611.35	9	9
99444		49.02	939.90	9	9
99446		32.68	239.95	4	4
99448			225.35	4	4
99450			352.20	6	6
99452			375.95	6	6



**SURGICAL PROCEDURES**  
**OPERATIONS ON ORGANS OF SPECIAL SENSES**  
**OPERATIONS ON THE EAR**

Code		G.P.	Assist	Spec.	Spec. Anaes.	G.P. Anaes.
<b>INNER EAR</b>						
<b>Incision</b>						
99470	Labyrinthotomy or labyrinthectomy Surgical including Tack or Fick procedures or ultrasound..		49.02	521.95	7	7
<b>Repair</b>						
99482	Fenestration of semicircular canals .....			348.80	6	6
99484	Stapes mobilization - unilateral .....			233.26	6	6
99486	Stapedectomy with prosthesis .....			644.54	6	6
99490	Endolymphatic shunt or sac decompression.....		32.68	629.60	9	9
99492	Temporal bone resection .....		32.68	1175.30	9	9
<b>Permanent Cochlear Prosthesis Insertion</b>						
99500	Extra-cochlear (round window, middle ear).....		57.19	509.00	9	9
99502	Intra-cochlear .....		57.19	719.71	9	9
99504	Bone conduction hearing aid insertion - implantable, including necessary mastoidectomy .....		32.68	317.60	6	6
<b>ACOUSTIC NERVE</b>						
99520	Translabyrinthine resection of acoustic neuroma (includes surgical approach and closure, any method).....		89.87	2673.21	15	15

Table VI

April 1, 2009

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

Units	Rate
1	\$8.17
2	\$16.34
3	\$24.51
4	\$32.68
5	\$40.85
6	\$49.02
7	\$57.19
8	\$65.36
9	\$73.53
10	\$81.70
11	\$89.87
12	\$98.04
13	\$106.21

Units	Rate
14	\$114.38
15	\$122.55
16	\$130.72
17	\$138.89
18	\$147.06
19	\$155.23
20	\$163.40
21	\$171.57
22	\$179.74
23	\$187.91
24	\$196.08
25	\$204.25

**Table V**

April 1, 2009

**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. Type 4 SHV's do not have a limitation. The rate listed is the rate per day after type 3 SHV's have concluded.
- D. 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.

<b>SHV - SUBSEQUENT HOSPITAL VISIT</b>								
Type SHV	Units	General Practice	Neurology	Obstetrics/ Gynecology	Pediatrics	Physical Medicine	Psychiatry	All Others
2	1	\$22.66	\$25.12	\$23.64	\$22.82	\$23.66	\$26.19	\$24.53
2	2	\$45.32	\$50.24	\$47.28	\$45.64	\$47.32	\$52.38	\$49.06
2	3	\$67.98	\$75.36	\$70.92	\$68.46	\$70.98	\$78.57	\$73.59
2	4	\$90.64	\$100.48	\$94.56	\$91.28	\$94.64	\$104.76	\$98.12
2	5	\$113.30	\$125.60	\$118.20	\$114.10	\$118.30	\$130.95	\$122.65
2	6	\$135.96	\$150.72	\$141.84	\$136.92	\$141.96	\$157.14	\$147.18
2	7	\$158.62	\$175.84	\$165.48	\$159.74	\$165.62	\$183.33	\$171.71
2	8	\$181.28	\$200.96	\$189.12	\$182.56	\$189.28	\$209.52	\$196.24
2	9	\$203.94	\$226.08	\$212.76	\$205.38	\$212.94	\$235.71	\$220.77
2	10	\$226.60	\$251.20	\$236.40	\$228.20	\$236.60	\$261.90	\$245.30
2	11	\$249.26	\$276.32	\$260.04	\$251.02	\$260.26	\$288.09	\$269.83
2	12	\$271.92	\$301.44	\$283.68	\$273.84	\$283.92	\$314.28	\$294.36
2	13	\$294.58	\$326.56	\$307.32	\$296.66	\$307.58	\$340.47	\$318.89
2	14	\$317.24	\$351.68	\$330.96	\$319.48	\$331.24	\$366.66	\$343.42
2	15	\$339.90	\$376.80	\$354.60	\$342.30	\$354.90	\$392.85	\$367.95
2	16	\$362.56	\$401.92	\$378.24	\$365.12	\$378.56	\$419.04	\$392.48
2	17	\$385.22	\$427.04	\$401.88	\$387.94	\$402.22	\$445.23	\$417.01
2	18	\$407.88	\$452.16	\$425.52	\$410.76	\$425.88	\$471.42	\$441.54
2	19	\$430.54	\$477.28	\$449.16	\$433.58	\$449.54	\$497.61	\$466.07
2	20	\$453.20	\$502.40	\$472.80	\$456.40	\$473.20	\$523.80	\$490.60

**SHV - SUBSEQUENT HOSPITAL VISIT**

Type SHV	Units	General Practice	Neurology	Obstetrics/ Gynecology	Pediatrics	Physical Medicine	Psychiatry	All Others
2	21	\$475.86	\$527.52	\$496.44	\$479.22	\$496.86	\$549.99	\$515.13
2	22	\$498.52	\$552.64	\$520.08	\$502.04	\$520.52	\$576.18	\$539.66
2	23	\$521.18	\$577.76	\$543.72	\$524.86	\$544.18	\$602.37	\$564.19
2	24	\$543.84	\$602.88	\$567.36	\$547.68	\$567.84	\$628.56	\$588.72
2	25	\$566.50	\$628.00	\$591.00	\$570.50	\$591.50	\$654.75	\$613.25
2	26	\$589.16	\$653.12	\$614.64	\$593.32	\$615.16	\$680.94	\$637.78
2	27	\$611.82	\$678.24	\$638.28	\$616.14	\$638.82	\$707.13	\$662.31
2	28	\$634.48	\$703.36	\$661.92	\$638.96	\$662.48	\$733.32	\$686.84
2	29	\$657.14	\$728.48	\$685.56	\$661.78	\$686.14	\$759.51	\$711.37
2	30	\$679.80	\$753.60	\$709.20	\$684.60	\$709.80	\$785.70	\$735.90
2	31	\$702.46	\$778.72	\$732.84	\$707.42	\$733.46	\$811.89	\$760.43
2	32	\$725.12	\$803.84	\$756.48	\$730.24	\$757.12	\$838.08	\$784.96
2	33	\$747.78	\$828.96	\$780.12	\$753.06	\$780.78	\$864.27	\$809.49
2	34	\$770.44	\$854.08	\$803.76	\$775.88	\$804.44	\$890.46	\$834.02
2	35	\$793.10	\$879.20	\$827.40	\$798.70	\$828.10	\$916.65	\$858.55
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

**SHV - SUBSEQUENT HOSPITAL VISIT**

Type SHV	Units	General Practice	Neurology	Obstetrics/ Gynecology	Pediatrics	Physical Medicine	Psychiatry	All Others
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
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

**SHV - SUBSEQUENT HOSPITAL VISIT**

Type SHV	Units	General Practice	Neurology	Obstetrics/ Gynecology	Pediatrics	Physical Medicine	Psychiatry	All Others
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
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











<b>EPIDURAL ANAESTHESIA FOR PAIN CONTROL</b>				
(Fee Codes 54134 and 80044)				
<b>TIME</b>		<b>Units</b>	<b>G.P. Anaes.</b>	<b>Spec. Anaes.</b>
<b>From</b>	<b>To</b>			
1 min	15 mins	1	<b>\$13.08</b>	<b>\$14.53</b>
16 mins	30 mins	2	<b>\$26.16</b>	<b>\$29.06</b>
31 mins	45 mins	3	<b>\$39.24</b>	<b>\$43.59</b>
46 mins	60 mins	4	<b>\$52.32</b>	<b>\$58.12</b>
61 mins	1 hr 15 mins	5	<b>\$65.40</b>	<b>\$72.65</b>
1 hr 16 mins	1 hr 30 mins	6	<b>\$78.48</b>	<b>\$87.18</b>
1 hr 31 mins	1 hr 45 mins	7	<b>\$91.56</b>	<b>\$101.71</b>
1 hr 46 mins	2 hrs	8	<b>\$104.64</b>	<b>\$116.24</b>
2 hrs 1 min	2 hrs 15 mins	9	<b>\$117.72</b>	<b>\$130.77</b>
2 hrs 16 mins	2 hrs 30 mins	10	<b>\$130.80</b>	<b>\$145.30</b>
2 hrs 31 mins	2 hrs 45 mins	11	<b>\$143.88</b>	<b>\$159.83</b>
2 hrs 46 mins	3 hrs	12	<b>\$156.96</b>	<b>\$174.36</b>

Maximum of 12 units payable per day

Table III

April 1, 2009

<b>ANAESTHETIC TIME UNITS - SURGICAL PROCEDURES</b>				
<b>Procedural fee codes with basic fee equal to 4 or 5 time units</b>				
<b>TIME</b>		<b>Units</b>	<b>G.P. Anaes.</b>	<b>Spec. Anaes.</b>
<b>From</b>	<b>To</b>			
1 min	15 mins	1	\$13.08	\$14.53
16 mins	30 mins	2	\$26.16	\$29.06
31 mins	45 mins	3	\$39.24	\$43.59
46 mins	60 mins	4	\$52.32	\$58.12
1 hr 1 min	1 hr 15 mins	5	\$78.48	\$87.18
1 hr 16 mins	1 hr 30 mins	6	\$104.64	\$116.24
1 hr 31 mins	1 hr 45 mins	7	\$130.80	\$145.30
1 hr 46 mins	2 hrs	8	\$156.96	\$174.36
2 hrs 1 min	2 hrs 15 mins	9	\$183.12	\$203.42
2 hrs 16 mins	2 hrs 30 mins	10	\$209.28	\$232.48
2 hrs 31 mins	2 hrs 45 mins	11	\$235.44	\$261.54
2 hrs 46 mins	3 hrs	12	\$261.60	\$290.60
3 hrs 1 min	3 hrs 15 mins	13	\$287.76	\$319.66
3 hrs 16 mins	3 hrs 30 mins	14	\$313.92	\$348.72
3 hrs 31 mins	3 hrs 45 mins	15	\$340.08	\$377.78
3 hrs 46 mins	4 hrs	16	\$366.24	\$406.84
4 hrs 1 min	4 hrs 15 mins	17	\$405.48	\$450.43
4 hrs 16 mins	4 hrs 30 mins	18	\$444.72	\$494.02
4 hrs 31 mins	4 hrs 45 mins	19	\$483.96	\$537.61
4 hrs 46 mins	5 hrs	20	\$523.20	\$581.20
5 hrs 1 min	5 hrs 15 mins	21	\$562.44	\$624.79
5 hrs 16 mins	5 hrs 30 mins	22	\$601.68	\$668.38
5 hrs 31 mins	5 hrs 45 mins	23	\$640.92	\$711.97
5 hrs 46 mins	6 hrs	24	\$680.16	\$755.56
6 hrs 1 min	6 hrs 15 mins	25	\$719.40	\$799.15
6 hrs 16 mins	6 hrs 30 mins	26	\$758.64	\$842.74
6 hrs 31 mins	6 hrs 45 mins	27	\$797.88	\$886.33
6 hrs 46 mins	7 hrs	28	\$837.12	\$929.92
7 hrs 1 min	7 hrs 15 mins	29	\$876.36	\$973.51
7 hrs 16 mins	7 hrs 30 mins	30	\$915.60	\$1,017.10

Table II

April 1, 2009

<b>ANAESTHETIC TIME UNITS - SURGICAL PROCEDURES</b>				
<b>Procedural fee codes with basic fee equal to 1-3 time units or 6 or more time units</b>				
<b>TIME</b>		<b>Units</b>	<b>G.P. Anaes.</b>	<b>Spec. Anaes.</b>
<b>From</b>	<b>To</b>			
1 min	15 mins	1	\$13.08	\$14.53
16 mins	30 mins	2	\$26.16	\$29.06
31 mins	45 mins	3	\$39.24	\$43.59
46 mins	60 mins	4	\$52.32	\$58.12
61 mins	1 hr 15 mins	5	\$65.40	\$72.65
1 hr 16 mins	1 hr 30 mins	6	\$78.48	\$87.18
1 hr 31 mins	1 hr 45 mins	7	\$91.56	\$101.71
1 hr 46 mins	2 hrs	8	\$104.64	\$116.24
2 hrs 1 min	2 hrs 15 mins	9	\$130.80	\$145.30
2 hrs 16 mins	2 hrs 30 mins	10	\$156.96	\$174.36
2 hrs 31 mins	2 hrs 45 mins	11	\$183.12	\$203.42
2 hrs 46 mins	3 hrs	12	\$209.28	\$232.48
3 hrs 1 min	3 hrs 15 mins	13	\$235.44	\$261.54
3 hrs 16 mins	3 hrs 30 mins	14	\$261.60	\$290.60
3 hrs 31 mins	3 hrs 45 mins	15	\$287.76	\$319.66
3 hrs 46 mins	4 hrs	16	\$313.92	\$348.72
4 hrs 1 min	4 hrs 15 mins	17	\$353.16	\$392.31
4 hrs 16 mins	4 hrs 30 mins	18	\$392.40	\$435.90
4 hrs 31 mins	4 hrs 45 mins	19	\$431.64	\$479.49
4 hrs 46 mins	5 hrs	20	\$470.88	\$523.08
5 hrs 1 min	5 hrs 15 mins	21	\$510.12	\$566.67
5 hrs 16 mins	5 hrs 30 mins	22	\$549.36	\$610.26
5 hrs 31 mins	5 hrs 45 mins	23	\$588.60	\$653.85
5 hrs 46 mins	6 hrs	24	\$627.84	\$697.44
6 hrs 1 min	6 hrs 15 mins	25	\$667.08	\$741.03
6 hrs 16 mins	6 hrs 30 mins	26	\$706.32	\$784.62
6 hrs 31 mins	6 hrs 45 mins	27	\$745.56	\$828.21
6 hrs 46 mins	7 hrs	28	\$784.80	\$871.80
7 hrs 1 min	7 hrs 15 mins	29	\$824.04	\$915.39
7 hrs 16 mins	7 hrs 30 mins	30	\$863.28	\$958.98

**ANAESTHESIA BASIC FEE CODE RATES**

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

<b>Listed Unit Value</b>	<b>General Practice Anaesthesiology Rate</b>	<b>Specialist Anaesthesiology Rate</b>
1	\$13.08	\$14.53
2	\$26.16	\$29.06
3	\$39.24	\$43.59
4	\$52.32	\$58.12
5	\$65.40	\$72.65
6	\$78.48	\$87.18
7	\$91.56	\$101.71
8	\$104.64	\$116.24
9	\$117.72	\$130.77
10	\$130.80	\$145.30
11	\$143.88	\$159.83
12	\$156.96	\$174.36
13	\$170.04	\$188.89
14	\$183.12	\$203.42
15	\$196.20	\$217.95
16	\$209.28	\$232.48
17	\$222.36	\$247.01
18	\$235.44	\$261.54
19	\$248.52	\$276.07
20	\$261.60	\$290.60
21	\$274.68	\$305.13
22	\$287.76	\$319.66
23	\$300.84	\$334.19
24	\$313.92	\$348.72
25	\$327.00	\$363.25
26	\$340.08	\$377.78
27	\$353.16	\$392.31
28	\$366.24	\$406.84
29	\$379.32	\$421.37
30	\$392.40	\$435.90

Table VII

April 1, 2009

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

<b>Units</b>	<b>Rate</b>
1	\$27.50
2	\$55.00
3	\$82.50
4	\$110.00
5	\$137.50
6	\$165.00
7	\$192.50
8	\$220.00
9	\$247.50
10	\$275.00
11	\$302.50
12	\$330.00
13	\$357.50

<b>Units</b>	<b>Rate</b>
14	\$385.00
15	\$412.50
16	\$440.00
17	\$467.50
18	\$495.00
19	\$522.50
20	\$550.00
21	\$577.50
22	\$605.00
23	\$632.50
24	\$660.00
25	\$687.50

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